U.S. Department of Labor

Office of Administrative Law Judges
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Issue Date: 20 October 2003

CASE NO.: 2002-LHC-2869

OWCP NO.: 07-160104

IN THE MATTER OF

ADA P. JOE,
Claimant

v.

NORTHROP GRUMMAN SHIP SYSTEMS,
Employer

APPEARANCES:

BILLY WRIGHT HILLEREN, ESQ.
On behalf of the Claimant

PAUL B. HOWELL, ESQ.
On behalf of the Employer

Before: LARRY W. PRICE
Administrative Law Judge

DECISION AND ORDER AWARDING BENEFITS

This is a claim for benefits under the Longshore and Harbor Workers' Compensation Act (herein the Act), 33 U.S.C. § 901, et seq., brought by Ada P. Joe (Claimant) against Northrop Grumman Ship Systems (Employer).

The issues raised by the parties could not be resolved administratively and the matter was referred to the Office of Administrative Law Judges for hearing. A formal hearing was held in Metairie, Louisiana, on July 9, 2003. All parties were afforded a full opportunity to adduce testimony, offer documentary evidence and submit post-hearing briefs. The following exhibits were received into evidence:

1. Joint Exhibit 1;
2. Claimant's Exhibits 1-32;and
3. Employer's Exhibits 1-26.

Based upon the stipulations of the parties, the evidence introduced, and the arguments presented, I find as follows:

I. STIPULATIONS

During the course of the hearing the parties stipulated and I find as related to Case No. 2002-LHC-2869 (JX-1):

1. Jurisdiction is not a contested issue. At the time of the alleged injury, the claimant was covered by the U.S. Longshore and Harbor Workers' Compensation Act since she was engaged in constructing naval vessels alongside the navigable waters of the Gulf of Mexico in Pascagoula, Mississippi, at Ingalls Shipbuilding, Inc.

2. Date of injury/accident: May 6, 2001.

3. Injury in course and scope of employment: Yes.

4. Employer/Employee relationship at time of accident: Yes.

5. Date employer advised of injury: Date is disputed, but parties agree timely notice was given.

6. Date Notice of Controversion filed: May 23, 2001.

7. Date of informal conference: August 7, 2001.

8. Nature and extent of disability:

    a. Temporary total disability paid from May 7, 2001, to October 28, 2001, at $311.23 per week. Total paid: $7,780.75.
    b. Medical benefits paid: Yes, except as to Dr. Herbert Allen, Dr. Ennis, Dr. Parker and Singing River Hospital emergency room.

II. ISSUES

The unresolved issues in this proceeding are:

1. Causation/fact of injury.

2. Average weekly wage.

3. Nature and extent of disability.

4. Section 7 medical benefits.

5. Section 8(f) relief.

6. Interest, attorney's fees and costs.

III. STATEMENT OF THE CASE

Claimant's Testimony

Claimant is a fifty-five year old woman who resides in Moss Point, Mississippi. She is a high school graduate. (Tr. 10). She has worked in Ingalls shipyard for twenty-nine years. (Tr. 10-11). Claimant has worked as a supervisor and a work leader at the shipyard, but for the last fifteen years, she has been a shipyard laborer. (Tr. 11). Claimant affirmed that she had to keep up with paperwork and reports when she worked as a supervisor and that she was never demoted due to lack of ability. Rather, Claimant was put back to work as a laborer because of lack of work in the shipyard. (Tr. 68).

In 1992, Claimant suffered a workplace injury to her neck. She treated with Dr. Warfield, the shipyard physician, who diagnosed her with tendonitis. (Tr. 68). She never saw an outside doctor for this injury. (Tr. 68-69). In October 1995, Claimant suffered a workplace injury to her back after lifting a bucket of water. At that time, Claimant also suffered from headaches and neck pain. She treated with Dr. John McCloskey, who prescribed pain medication and muscle relaxers. (Tr. 27, 69). Claimant was able to return to regular duty without restrictions after this back injury. (Tr. 27).

In 1996, Claimant treated with Dr. Calvin Ennis, her family physician, for psychiatric problems, migraines and stomach problems. (Tr. 69-70). She affirmed that she was diagnosed with an adjustment disorder, dysthymia and depression. (Tr. 70-71). Dr. Ennis continued to treat Claimant for these problems from 1996 through 2000 or 2001. (Tr. 71). Claimant took Xanax, Valium and another medication for her psychiatric problems. (Tr. 71-72). She also took Imitrex for her migraines.

Claimant denied having a recurrence of her neck problems in 1998. She did not recall having intermittent neck problems up until the workplace injury in question, but she did acknowledge having headaches on an intermittent basis during this time. (Tr. 72).

In the year before Claimant's workplace injury occurred in May 2001, she had missed some time from work due to personal matters, including deaths in her family and

her own health problems. (Tr. 15-16, 106). Claimant testified that she suffered from stomach problems, migraine headaches and depression. (Tr. 16). Claimant took several leaves of absence to deal with these personal issues before returning to work. (Tr. 16-17, 106). She affirmed that she was out on medical leave for her medical conditions in June-July 2000 and from February 20, 2001, through March 28, 2001. (Tr. 108). Claimant got a non-industrial leave of absence on March 29, 2001, and was reinstated from her leave on April 17, 2001, at which point she resumed her full duty work. (Tr. 108-09).

Claimant's duties as a laborer included cleaning and sweeping out ship compartments before ships were sold to the Navy. (Tr. 12). Her cleaning tools included a mop, broom, touch up paintbrush, rags, soap and water, all of which were carried in a five gallon bucket. (Tr. 12-13). Claimant estimated that the bucket weighed about five to ten pounds, depending upon how many tools it contained. The supervisor assigned the laborers to certain work areas. (Tr. 14). Claimant testified that she sometimes had to climb into tight spaces or under pipes in order to clean, and she also used a ladder to do overhead work. (Tr. 13-14). Claimant worked eight hours a day, forty hours a week. (Tr. 20). She also worked overtime. (Tr. 20-21).

Claimant was performing her usual duties as a laborer at the time of her workplace injury on May 6, 2001. (Tr. 15). Claimant was cleaning bilges in an engine room, and she had crawled under some pipes and was cleaning in a small hole when her accident occurred. (Tr. 17-18). As Claimant attempted to crawl on her stomach back out of the area beneath the pipes, she lifted up her body before she moved clear of the pipes. Her neck and back hit the pipes, and Claimant lay on her stomach for some time before backing out of the hole. When Claimant moved out of the hole with her cleaning supplies, she sat down and told a co-worker, Betty Jean Stennis, that she had jammed her neck and back and was in a lot of pain. (Tr. 18).

Claimant finished work that day and told her foreman, D.D. Kelley, about her injury. Claimant did not inform her supervisor of the injury because he was not in the work area. When Claimant left work, she was in a lot of pain. (Tr. 19). She was unable to return to work the next day, which was a Monday. Claimant called Mr. Kelley and explained that she could not get out of bed and needed to see a doctor. (Tr. 21). Mr. Kelley told Claimant that she should go to the doctor. Claimant made an appointment for Wednesday with Dr. Charlton Barnes, an orthopedic surgeon. She testified that this appointment was the earliest available time for Dr. Barnes to see her. In the meantime, Claimant saw her gynecologist, Dr. Paul Allen, on Monday for an unrelated bladder infection. (Tr. 22). Claimant testified that she told Dr. Allen about her accident, and she was unaware that there was no mention of the accident in Dr. Allen's records. According to Claimant, Dr. Allen told her to see an orthopedic surgeon and she told him that she had made an appointment with Dr. Barnes. (Tr. 74). Claimant denied that she told Dr. Allen that she had made an appointment with Dr. Lawrence, despite what his records indicated. (Tr. 74-75).

When Claimant saw Dr. Barnes, she filled out a form detailing her reasons for being in his office. (Tr. 109-11). She complained of neck and back pain as well as numbness in her right side, including her arm, legs and feet and tingling in her fingers. (Tr. 24, 76, 110-11). Claimant testified that she told Dr. Barnes about her previous neck and back problems when she related the history of her workplace accident. Although Dr. Barnes' records indicated that Claimant complained of knee problems, Claimant explained that she told Dr. Barnes that she had leg problems, not knee problems. (Tr. 76). Claimant affirmed that Dr. Barnes had previously performed foot surgery on her in 1995. (Tr. 77). In regards to the workplace injury in question, Claimant acknowledged that she signed a choice of physician form selecting Dr. Barnes as her orthopedic doctor and that Employer authorized her treatment with Dr. Barnes. (Tr. 78). Dr. Barnes ordered an MRI and CT scan and prescribed some pain medication for Claimant. (Tr. 24). He also took Claimant off work. Claimant testified that after the tests were completed, Dr. Barnes diagnosed her with shoulder tendonitis as well as some sort of lumbar disc problem. (Tr. 25). Dr. Barnes eventually ordered a second bone scan for Claimant. She affirmed that Dr. Barnes told her the scan results were normal. (Tr. 80).

Claimant acknowledged that she saw Dr. Guy Rutledge at Employer's behest in July 2001. She testified that Dr. Rutledge told her that she needed to find another job because she was getting too old to do the work of a laborer. She recalled that Dr. Rutledge told her that he thought she could return to work at that time. (Tr. 79). Claimant explained that she did not return to work then because she was still off work under Dr. Barnes. (Tr. 79-80).

Dr. Barnes sent Claimant to physical therapy and later referred her to Dr. John McCloskey, a neurosurgeon, who also prescribed pain medication and a course of physical therapy. (Tr. 25-26, 80). Dr. McCloskey sent Claimant to Dr. Terry Millette,[1] a neurologist, for a nerve test. (Tr. 28, 80). Claimant affirmed that Dr. Millette told her that her nerve test results were normal. (Tr. 80). Claimant acknowledged that Employer authorized her change of physicians from Dr. Barnes to Dr. McCloskey. (Tr. 81). Although she apparently never had to pay any of Dr. McCloskey's bills out of her own pocket, Claimant noted that she once had to pay a co-pay at Dr. Barnes' office and she did not know whether Employer ever reimbursed her for that expense. (Tr. 80-81). Dr. McCloskey told Claimant that she did not need surgery and referred her to Dr. Edward Schnitzer, a pain specialist. (Tr. 28, 82). Claimant affirmed that Employer authorized her to see Dr. Schnitzer and paid all her medical bills relating to Dr. Schnitzer's treatment. (Tr. 82).

Claimant continued to be treated by Dr. Barnes while seeing Dr. Schnitzer. Dr. Barnes released Claimant to light duty work in October 2001. Claimant's restrictions included no lifting over ten to twenty pounds. (Tr. 29). Claimant received a lump sum payment from workers' compensation in August 2001, and Employer paid her $622

[1] Although the transcript indicates that Dr. McCloskey referred Claimant to a Dr. Gillette, the medical records indicate that in fact Claimant saw Dr. Millette. (CX. 11, p. 25; CX. 12, p. 17).

every two weeks thereafter until she returned to work. (Tr. 29-30). Claimant continued her physical therapy treatments, which included massages, low back injections and home exercises. The physical therapist gave Claimant a TENS unit machine, which she used at home every night. Claimant also applied heat and over the counter creams to alleviate her pain. Claimant took various medications, including Darvocet, Xanaflex and Neurontin. (Tr. 31).

Claimant returned to work on October 29, 2001. (Tr. 83). Claimant testified that she resumed her regular duties, her regular hours and her regular wage upon returning to work. (Tr. 32, 83-84). She continued to clean ship compartments but no longer had to crawl in holes and under pipes. Claimant did have to climb ladders to do overhead work but agreed that her work was easier than the work she had done at the time of her workplace accident. Claimant continued at this work assignment for about four months. (Tr. 33). At that point, Claimant was reassigned to a job on the USS Cole, which was being repaired at the shipyard. Claimant and a co-worker had to pump water out of the ship. (Tr. 34). Claimant's co-worker worked the pump on the ground, while Claimant had to go into the ship, put the pump line into a space and then move it around to pump all the water out. According to Claimant, the pump line was about four inches in diameter and was made of rubber. (Tr. 35). She explained that the length of the pump line varied, depending on where she needed to go on the ship. (Tr. 36-37). The pump line also had a small attachment that Claimant used whenever she had to pump water out of small areas.

Claimant worked the pump line on the Cole for about a month and a half or two months. (Tr. 38). She testified that this job was completely different from her cleaning job, where she was not required to do a lot of walking and pulling. Claimant's neck, back and legs started to hurt because of all the walking she had to do on the Cole. (Tr. 39). She affirmed that her previous symptoms had returned. Although Claimant had pain medication, she did not take it at work because the prescription contained a warning not to work around machinery while taking medication. Claimant also used her vacation days when she missed work to avoid getting a warning slip. (Tr. 40). Claimant did not receive any warning slips during this time. (Tr. 84). Claimant did not know why none of her doctors indicated that she had problems pulling hoses while she was at work. (Tr. 86).

After leaving the Cole, Claimant was assigned to another ship, where she was required to clean the tanks and engine rooms. (Tr. 41-42). Claimant did a lot of overhead work and also had to crawl through small holes to clean the various tank sections. (Tr. 42). She testified that this work, which was the same sort of work she had done before her workplace accident, created a lot of stress on her and caused her symptoms to flare up again. (Tr. 42-43). Although Claimant underwent another MRI scan during this period, she continued to work and no doctors pulled her from work before May 3, 2002, except for a short period of time in April 2002 when Dr. Schnitzer

took Claimant off work for a week because of her pain. (Tr. 43, 84). Claimant received no workers' compensation for that week. (Tr. 44).

On April 24, 2002, Dr. Barnes referred Claimant to Dr. McCloskey for a consult, but the insurance company did not approve the referral. (Tr. 44-45). Although Claimant was no longer approved to see Dr. Barnes, she was still approved to see Dr. Schnitzer. Claimant's last day of work at the shipyard was May 3, 2002. (Tr. 45). On May 4, 2002, Claimant's sister died, so she took time off to be with her family. (Tr. 85).

She attempted to make an appointment with Dr. Schnitzer, but he was already booked for the next three or four weeks. Claimant instead went to see Dr. Ennis, who pulled her from work. (Tr. 46). Claimant acknowledged that she was upset about her sister's death when she saw Dr. Ennis, but she did not know why his notes did not reflect her complaints of neck or back pain. (Tr. 85-86). Claimant denied that she attempted to have Dr. Ennis take her off work because of her sister's death. (Tr. 86, 112). She affirmed that Employer would not authorize compensation benefits for any time missed due to her sister's death. (Tr. 86-87). Claimant affirmed that her family's various medical problems did affect her but denied that the reason that she never returned to work after May 3, 2002, was because of her sister's death. (Tr. 112-13).

Eventually, Dr. Schnitzer referred Claimant to Dr. McCloskey. (Tr. 46). Although this appointment was scheduled for the beginning of June, Claimant did not see Dr. McCloskey until July 4, 2002. (Tr. 46-47). Dr. McCloskey prescribed some pain medication and sent Claimant to physical therapy. (Tr. 47). Claimant's physical therapist made some recommendations and administered a functional capacity evaluation (FCE). (Tr. 48). On August 1, 2002, Dr. McCloskey took Claimant off work, retroactive to June 12. (Tr. 47-48). He also recommended epidural shots, which were approved by Dr. Schnitzer. (Tr. 48). Claimant received two of these shots in her neck.

Although the epidural shots relieved some of the pressure and soreness from Claimant's neck and shoulder, she still experienced no relief from her back pain. (Tr. 49). Dr. McCloskey referred Claimant back to Dr. Schnitzer, and Employer once again authorized this treatment. (Tr. 88). When Claimant saw Dr. Schnitzer in October 2002, she asked him to allow her to see Dr. Herbert Allen, an orthopedist, for a second opinion. (Tr. 49-50). The insurance company denied this request. (Tr. 50). Claimant underwent another FCE and another epidural while treating with Dr. Schnitzer. (Tr. 88-89). On November 24, 2002, Dr. Schnitzer determined Claimant had reached MMI and returned her to work with restrictions. (Tr. 49, 89). Claimant did not know that Dr. Schnitzer had assigned her a five percent impairment to the neck and zero percent impairment to the back. (Tr. 89).

When Claimant returned to the shipyard with her restrictions, she was told that Employer could not return her to work with those restrictions. Claimant then went to the Mississippi state employment office to look for work on the computer database.

However, she was told that it was unlikely that any other employer would hire her, given her restrictions. (Tr. 51). Claimant explained that although she did find some local jobs within her restrictions, as a cook or a cashier, these jobs did not pay as well as her shipyard job. (Tr. 52, 92). Claimant testified that she never applied for a job at Grand Casino, Pinkerton's Security, Munro Petroleum or Imperial Palace because "I was sick." (Tr. 91-92). In addition, Claimant explained that she was upset because even though she had worked for Employer for twenty-eight years, they could not find any work for her to do within her restrictions. (Tr. 92).

On February 24, 2003, Claimant reported back to Employer to see about a job within her restrictions. (Tr. 53). Claimant affirmed that she met with Melinda Wiley, who told her to keep a copy of her restrictions and to make everyone familiar with them. (Tr. 93). Claimant agreed that Ms. Wiley also told her that her job would be modified to fit within the restrictions, that she should not work outside the restrictions and that she should report to Ms. Wiley if she had any problems doing the work. (Tr. 93-94). Claimant did not take any medication that morning because the medication would make her drowsy and unable to work. (Tr. 53-54).

After Claimant was processed back in to work, she reported to her foreman. (Tr. 54). Claimant had to walk about half a mile to reach the foreman, who then sent her to a ship to report to her supervisor. (Tr. 55). Claimant's supervisor assigned her to a work area, and when Claimant reached her work area, she told the supervisor that she was in a lot of pain. (Tr. 55-56). Nonetheless, Claimant did the job that she was assigned. Claimant had to clean a small compartment which contained a desk, a shelf and a machine. Then she swept the deck around the area. (Tr. 56). Claimant had to do some overhead work in order to clean the shelf. (Tr. 56-57).

When Claimant's supervisor came back to check on her, Claimant again reported that she was in a lot of pain. The supervisor told Claimant to take her medication, since it was almost time to go home. (Tr. 57). Claimant testified that by the time she got home, she hurt all over and could hardly move. She affirmed that her pain was similar to the pain that she experienced from her initial workplace accident. (Tr. 58). Claimant's first day back at work was a Monday, and she had asked for Tuesday off because her daughter was undergoing surgery. (Tr. 59, 94-95).

When Claimant returned to work on Wednesday, she was assigned the same duties that she had been assigned on Monday. Claimant began working at 7:00 a.m. but left work at 11:30 a.m. because she was having pain in her neck, back and legs. (Tr. 60). Claimant told her supervisor that she was in pain, and her supervisor called someone to give Claimant a ride from the ship to the shipyard gate. (Tr. 60-61). That was Claimant's last day to work in the shipyard. (Tr. 61). She testified that she tried to do the work but was in too much pain. In addition, Claimant was afraid to take her narcotics pain medication because she did not want to fall asleep at work and risk losing her job. (Tr. 61, 96).

Claimant eventually went to see Dr. Herbert Allen on her own through a referral from Dr. Ennis. (Tr. 52-53). She acknowledged that she never requested authorization for treatment with Dr. Ennis. (Tr. 103-04). Claimant affirmed that neither Dr. McCloskey nor Dr. Schnitzer ever referred her back to Dr. Barnes. (Tr. 89-90). Claimant testified that she also asked Dr. Schnitzer to refer her to Dr. Allen, but he was unable to get workers' compensation to approve the referral. (Tr. 99). She was unaware that Dr. Schnitzer did not feel that the referral was necessary. (Tr. 99-100). She agreed that neither Dr. McCloskey nor Dr. Schnitzer has ever refused her treatment and that she has never paid any of their bills. (Tr. 90).

Claimant testified that Dr. Allen examined her, checked her reflexes, observed her walking and gave her two low back injections. (Tr. 62). She explained that this examination was different from her visits to Dr. Schnitzer because Dr. Schnitzer only prescribed medication and never examined her, other than on one occasion when he tapped her on the shoulder and noted that it was tender. (Tr. 62, 114). Claimant stated that she had never had any other injections like the ones that Dr. Allen gave her, and she did experience relief from these shots. (Tr. 62-63).

Dr. Allen took Claimant off work, and she turned in the off work slip to Employer. (Tr. 64). Claimant was terminated but later reinstated. Claimant attempted to return to work with her restrictions in May 2003, but she was not hired back based on her restrictions. (Tr. 65). Since her last day of work at the shipyard in February 2003, Claimant has looked for work at the state employment office, as well as at several different check cashing places and a Family Dollar store, but none of these places were hiring at the time. (Tr. 66).

Claimant has seen Dr. Allen several times. However, the last time that she attempted to see him, about a week before the hearing in this case, she was refused treatment because Dr. Allen's bill had not been paid and workers' compensation did not cover it. (Tr. 64). Dr. Allen wants Claimant to undergo another FCE as well as physical therapy. (Tr. 66). These recommendations have not been approved by Employer. Claimant has received no compensation from Employer since October 2001. (Tr. 67).

Deposition of Edward Schnitzer, M.D.

Dr. Schnitzer is a physician specializing in physical medicine and rehabilitation. (CX. 30, p. 6). He first saw Claimant on October 12, 2001, on a referral from Dr. McCloskey. (CX. 30, p. 7). At that time, Claimant reported that initially, she had injured her back at work in 1995 but had improved from that injury. She then related the history of her May 2001 workplace accident and subsequent treatment. Claimant told Dr. Schnitzer that Dr. Barnes had sent her to physical therapy for about three months, which offered her temporary relief. (CX. 30, p. 8). When Claimant did not improve, she was seen by Dr. McCloskey, who had no surgical recommendations. Dr. Millette performed electrodiagnostic testing on both upper limbs; the results were normal. Claimant had not

undergone any epidural steroid injections and had remained off work since her accident. (CX. 30, p. 9).

In terms of physical studies, a cervical MRI from May 2001 revealed a disc bulge on the right side at C5-6, causing some spinal stenosis. Some osteophytic or arthritic changes were also present. (CX. 30, p. 8). A lumbar MRI, also from May 2001, revealed no evidence of significant disc disease or disc herniation but did indicate arthritic-type wear and tear changes. (CX. 30, pp. 8-9).

On Claimant's first appointment with Dr. Schnitzer, she complained of persistent neck pain and tightness. She reported that the pain worsened with physical activities but improved somewhat with pain medication and local heat. Claimant had pain radiating down both arms, with more pain on the right side, and some numbness in her fingers. Claimant also had intermittent radiation down her right leg. She reported that her back pain worsened with walking and moving but improved somewhat with medications and lying down. (CX. 30, p. 9). Dr. Schnitzer testified that it was possible that these complaints were consistent with the MRI findings.

Upon examination, Dr. Schnitzer noted that Claimant had an active range of motion in her neck, with some slightly decreased lateral rotation in both directions. Her motor, sensory and reflex exams were all normal. (CX. 30, p. 11). Claimant had some tightness in her bilateral trapezius muscles with local radiation on palpation and multiple tender points throughout the chest, upper back, arms and hands. (CX. 30, pp. 11-12). Claimant's range of motion in her trunk was within functional limits in all directions, and she had full strength throughout her lower limbs. A straight leg raising test was negative. Claimant had some bilateral low lumbar paraspinal tenderness on palpation. The heel and toe walk was satisfactory. The Waddell's test was positive, as bilateral passive torsion movements of the trunk and hips elicited neck, low back and right side pain and very light axial compression on both shoulders caused low back and neck pain. (CX. 30, p. 12). Dr. Schnitzer explained that these positive Waddell's signs indicated non-organic back findings. (CX. 30, pp. 55-56).

Dr. Schnitzer determined that Claimant had a history of cervical disc disease with spondylosis and myofascial pain. He found no evidence of cervical radiculitis. Dr. Schnizter also found chronic low back pain with radicular and myofascial features as well as some non-organic findings of neck and low back pain. (CX. 30, p. 12). Dr. Schnitzer and Claimant discussed her condition and set out some goals, including decreasing pain intensity by at least fifty percent while improving and maximizing functional capabilities. He prescribed Celebrex, an anti-inflammatory medication, and told Claimant to try to decrease the amount of pain medication she was taking. He advised that trigger point injections might offer some relief and referred Claimant to work conditioning with physical therapist Ruth Bosarge for three to four weeks. Dr. Schnitzer explained that at the end of that time, he would recommend a functional assessment or a formal FCE to determine Claimant's capabilities and restrictions. He then hoped to make MMI and

impairment rating recommendations. He recommended that Claimant continue using her TENS unit and see him again in three weeks. (CX. 30, p. 13).

Dr. Schnitzer testified that there is typically no cure for arthritic changes or disc herniations and that treatment of these problems is a matter of managing the process. He hoped to minimize Claimant's symptoms but did not think it was realistic to think that they would disappear. (CX. 30, p. 14).

Claimant began undergoing physical therapy with Ms. Bosarge in early November 2001. Ms. Bosarge's notes indicated that Claimant had consistently reported problems with performing overhead work. Dr. Schnitzer testified that people with neck problems often have difficulty doing overhead work. (CX. 30, p. 15). When Dr. Schnitzer saw Claimant on November 30, 2001, he prescribed Neurontin to help with Claimant's radiating pain symptoms and continued her prescriptions of Darvocet and Zanaflex. His impressions of her condition remained the same.

Dr. Schnitzer continued to see Claimant on a regular basis. (CX. 30, p. 16). On February 15, 2002, Claimant reported increased neck and low back pain related to work activities. (CX. 30, pp. 15-16). At that time, Claimant continued to take Zanaflex and Neurontin, but Dr. Schnitzer started prescribing Ultracet instead of Darvocet. Claimant continued to be on modified duty. (CX. 30, p. 17). Dr. Schnitzer ordered another cervical MRI, which was performed on April 9, 2002. (CX. 30, pp. 17-18). The MRI showed spinal stenosis at C5-6, probably secondary to disc herniation. It showed no changes since the May 2001 cervical MRI. Dr. Schnitzer explained that cervical spinal stenosis can cause weakness of the arms and/or legs as well as several other kinds of sensory changes and even bowel and bladder dysfunction. (CX. 30, p. 18). Because Claimant's exam had indicated full strength in both upper and lower limbs, Dr. Schnitzer concluded that she did not have severe stenosis. (CX. 30, pp. 18-19).

On April 12, 2002, Claimant continued to have neck and low back pain. She continued to take the same pain medications. Claimant told Dr. Schnitzer that she had missed the previous week of work due to pain. Her exam was essentially unchanged. Dr. Schnitzer advised Claimant to continue with her medication and her limited duty work, pending an FCE scheduled for the next week. (CX. 30, p. 19). He gave Claimant a return to work slip on April 15 with an excuse for April 8-12, the days that she missed. (CX. 30, pp. 19-20). An FCE performed on April 17, 2002, indicated that Claimant was able to work in the light physical demand category. The results indicated that Claimant had given a poor effort during the evaluation. Waddell's signs were negative. (CX. 30, p. 20). The FCE showed that Claimant should be able to do occasional lifting of up to twenty-two pounds, frequent lifting of up to fifteen pounds, occasional bending, squatting, kneeling, crawling and climbing and frequent sitting, standing, walking and reaching. (CX. 30, pp. 20-21).

Dr. Schnitzer testified that the myelogram and post-myelogram CT scans taken on July 16, 2002, revealed normal lumbar findings, other than moderate facet anthropathy at L4-5, which Dr. Schnitzer described as changes in the bones to keep the spine supported. (CX. 30, p. 21). The cervical myelogram studies showed smooth defects at C3-4, C4-5 and C5-6 as well as minimal disc bulge at C4-5, modest spinal stenosis at C5-6 secondary to bulge and associated osteophytes and some erosive changes in the uncovertebral joints. (CX. 30, p. 21; CX. 12, p. 64).

Dr. Schnitzer testified that Dr. McCloskey sent him a note dated August 1, 2002, indicating his impression of Claimant's condition, which was suspected symptomatic disc herniation at C5-6 with radiculopathy in the right arm and suspected symptomatic lumbar canal stenosis at L4-5 with radiculopathy in the right leg. (CX. 30, p. 23). Dr. Schnitzer noted that, in contrast with Dr. McCloskey, he did not document radiculitis in his examination of Claimant. (CX. 30, p. 24). Dr. Schnitzer testified that Claimant never showed evidence of cervical or lumbar radiculitis on any exam, meaning that there was no evidence of nerve root irritation in either the physical exams or the diagnostic studies. (CX. 30, pp. 60-62). He observed that Dr. McCloskey felt that Claimant had identifiable neck and back problems but also felt that Claimant's problems were not that severe and did not absolutely correlate to her symptoms, such that he was reluctant to recommend surgery. He agreed that there was some inconsistency between Claimant's subjective complaints of pain and the objective findings. (CX. 30, p. 57). Dr. Schnitzer noted that he had no reason to doubt Dr. McCloskey's opinion and would not argue with his findings.

When Dr. Schnitzer saw Claimant on August 30, 2002, his impressions remained the same. Claimant had full strength and the Spurling maneuver was negative. Dr. Schnitzer prescribed Naprelan, an anti-inflammatory medication, and Tylenol 3 for pain control and told Claimant to continue her other medications. (CX. 30, p. 24). Dr. McCloskey had suggested a cervical epidural steroid injection, and Dr. Schnitzer approved of that recommendation. (CX. 30, pp. 24-25). He also suggested another electrodiagnostic test to determine whether radiculopathy was present. He further noted that Claimant might need an updated FCE. He kept Claimant off work until her next visit. (CX. 30, p. 25).

On October 2, 2002, Employer's insurance adjuster requested Dr. Schnitzer's opinion on whether or not Claimant should return to work with light duty restrictions and asked Dr. Schnitzer what restrictions he would assign. (CX. 30, p. 26). In a letter dated October 10, 2002, Dr. Schnitzer outlined his recommendations, including a recommendation that Claimant should be referred to two weeks of physical therapy due to her increased symptoms and that she should be referred for a cervical epidural. Dr. Schnitzer indicated in his letter that after observing how Claimant responded to these treatments, he would refer her for another FCE. At that point, Dr. Schnitzer hoped to make recommendations as to Claimant's work status. Until then, Dr. Schnitzer recommended that Claimant remain off work. (CX. 30, p. 27).

When Dr. Schnitzer saw Claimant on October 24, 2002, she reported increased persistent neck and low back pain as well as pain in her arms and legs. (CX. 30, pp. 27-28). Claimant told Dr. Schnitzer that the Neurontin was not helping her but that the cervical epidural had given her about two weeks of relief. (CX. 30, p. 28). Dr. Schnitzer explained that patients may receive months of relief from an epidural. If a patient receives less than a week of relief, the relief is probably due to the local anesthetic and the epidural probably did not have much effect. (CX. 30, p. 29). Receiving two weeks of relief, as Claimant did, is an indication that the patient may benefit from a repeat block or a series of three. (CX. 30, pp. 28-29).

Dr. Schnitzer's impressions on this visit were disc herniation, chronic neck pain, lumbar facet arthropathy and lumbar area stenosis. He prescribed Darvocet, Zanaflex and Neurontin. (CX. 30, p. 29). Claimant was to start physical therapy the following week. Dr. Schnitzer planned to consider lumbar facet blocks to help Claimant's back situation. Claimant was to stay off work until her next visit, three to four weeks later. (CX. 30, p. 30). At Claimant's request, Dr. Schnitzer referred her to Dr. Herbert Allen for a second opinion. (CX. 30, pp. 30-31). Dr. Schnitzer noted that while he did not initiate the referral and would not have necessarily recommended it of his own volition, he did not have a problem with deferring to Claimant's request. (CX. 30, pp. 31, 87, 90-91). He affirmed that Employer's insurance adjuster denied the request to see Dr. Allen for a second opinion. (CX. 30, p. 88).

By the time of the November 20, 2002 appointment, Claimant had undergone another cervical epidural, which had relieved her neck and arm symptoms. (CX. 30, p. 31). Claimant's pain had decreased, and she remained on the same medications. (CX. 30, pp. 31-32). In addition, Claimant had undergone another FCE, which indicated that she had given maximum effort without symptom magnification. She was able to lift up to thirty-five pounds occasionally and fifteen pounds frequently. Claimant was able to do frequent crawling, squatting and reaching above the shoulder. (CX. 30, p. 33). Dr. Schnitzer had assigned Claimant a whole person impairment rating of five percent based on her cervical disc herniation but had assigned no impairment to the lumbar area. (CX. 30, pp. 48-49). Dr. Schnitzer testified that if asked to assign an impairment rating to the back, he would have assigned a zero percent impairment rating. (CX. 30, pp. 67-68).

Dr. Schnitzer designated November 25, 2002, as Claimant's MMI/return to work date and imposed some restrictions, including a lifting limit of thirty-five pounds occasionally and fifteen pounds frequently, no constant squatting, overhead work or crawling and no work at unprotected heights. (CX. 30, pp. 32, 42). Dr. Schnitzer was unaware whether the lumbar facet block that he ordered was ever performed, but he noted that Claimant later underwent some injections with Dr. Allen in March 2003. (CX. 30, p. 32).

On January 3, 2003, Claimant continued to complain of neck and low back pain and reported ringing in her ears and occasional bilateral leg weakness. She continued to

take the same medications. Dr. Schnitzer recommended that Claimant decrease her medication, as it might be the cause of her ears ringing. (CX. 30, p. 35). Dr. Schnitzer told Claimant to continue ice and heat and to call if her symptoms persisted. He recommended vocational rehabilitation if she could not be returned to her former place of employment.

Dr. Schnitzer last saw Claimant on March 14, 2003. She continued to have neck and low back pain, but the intensity of her pain had decreased. Dr. Allen had treated Claimant with a cortisone injection in her low back, which had helped her symptoms. (CX. 30, p. 36). Dr. Schnitzer was unclear, however, as to the specifics of the injections given to Claimant. (CX. 30, p. 37). She continued to take the same medications. Her exam was unchanged, as were Dr. Schnitzer's impressions of her condition. Dr. Schnitzer prescribed Bextra, an anti-inflammatory medication, and recommended that Claimant continue with the Zanaflex and Darvocet. Claimant told Dr. Schnitzer that she was going to see Dr. Allen again on March 26, and he noted that she seemed to benefit from her treatment with Dr. Allen. Dr. Schnitzer retained Claimant's restrictions and planned to see her again in three months.

Dr. Schnitzer was unaware that Claimant had unsuccessfully attempted to return to work in February 2003. (CX. 30, p. 37). When asked whether he would have modified Claimant's restrictions based on the fact that her pain increased when she attempted to return to work, Dr. Schnitzer explained that it would depend on what specific activities aggravated her symptoms and whether she worked outside her restrictions. (CX. 30, pp. 37-38). He noted that patients with cervical stenosis often have the most difficulty with overhead activities, so he might have modified Claimant's restriction from no continuous overhead activity (i.e., more than two-thirds of the day) to no frequent overhead activity (i.e., about two-thirds of the day). (CX. 30, p. 40). When asked if he would consider reducing the number of pounds in Claimant's lifting restrictions, Dr. Schnitzer explained that it would depend on how much weight Claimant was lifting overhead as opposed to how much weight she was lifting to the shoulder and below. (CX. 30, p. 41). He noted that lifting in front is not as stressful on the neck as lifting overhead, and he agreed it was possible that he might reduce the amount of overhead lifting for Claimant. (CX. 30, pp. 41-42). Dr. Schnitzer also agreed that he might further restrict Claimant's stair climbing and bending if she had trouble with these activities at work. (CX. 30, p. 42).

Dr. Schnitzer affirmed that in his opinion, based upon the information that he had, the conditions for which he treated Claimant were causally related to her May 2001 workplace accident. (CX. 30, pp. 42-43). When asked whether he would agree with Dr. Allen's recommendation that Claimant be off work for her low back condition during March and April 2003, Dr. Schnitzer testified that it would depend on Dr. Allen's findings. (CX. 30, pp. 43-45). He noted that based on his own findings, there were no significant indications that Claimant needed to remain out of work because of her low back condition. He further noted that he could not say beyond a reasonable doubt that Claimant's lumbar spine changes were related to her May 2001 workplace accident.

(CX. 30, p. 45). Dr. Schnitzer pointed out that Claimant had sustained a previous back injury. (CX. 30, p. 45). Dr. Schnitzer affirmed that stenosis takes some time to build up, so it is difficult to say whether it occurred before or after the workplace injury. (CX. 30, p. 50). Although he acknowledged that her May 2001 accident might have exacerbated the previous back injury, Dr. Schnitzer felt that the MRI changes and facet arthropathy were probably already there before the work injury at issue in this case occurred. (CX. 30, p. 46). His findings suggested a more chronic onset of neck and low back conditions prior to the accident. (CX. 30, p. 51). Dr. Schnitzer noted that both he and Dr. McCloskey found inconsistent findings on Claimant's physical exams. In any case, he would defer to Dr. Allen's opinion, although he could not necessarily agree with it based on his own information about Claimant's condition. (CX. 30, p. 47).

When asked to examine a medical report from Dr. Paul Allen, dated one day after Claimant's May 2001 workplace accident, Dr. Schnitzer affirmed that the report indicated no history of Claimant's accident and no complaints of neck pain. (CX. 30, p. 52). Dr. Schnitzer affirmed that Dr. Barnes' medical report, dated three days after the workplace accident, did not indicate any history of Claimant striking her neck on a pipe at work or any neck pain complaints. (CX. 30, p. 53). Dr. Schnitzer observed that the information that he obtained from Claimant was not consistent with the history provided by these two doctors. (CX. 30, p. 54). He affirmed, however, that the LS-202 in this case, filed on May 18, 2001, indicated that Claimant did describe the accident in the same way to Employer and to Dr. Schnitzer. (CX. 30, pp. 81-83). When told that Dr. Paul Allen is a gynecologist, Dr. Schnitzer did not think it unusual that Claimant would not have complained of her back and neck pain while seeing Dr. Allen for a gynecological complaint. (CX. 30, p. 84).

Dr. Schnitzer testified that during the early stage of his treatment of Claimant, Claimant's condition did seem to improve, particularly between October 2001 and December 2001. More recently, however, Dr. Schnitzer felt that Claimant's pain had gotten worse and then had improved again after Dr. Allen administered an epidural. On the whole, Dr. Schnitzer characterized Claimant's condition as "up and down." (CX. 30, p. 66). In Dr. Schnitzer's opinion, Claimant is not totally disabled and she is able to return to work in some capacity. (CX. 30, p. 68). According to Dr. Schnitzer, it is always good for patients to return to work as soon as they are able to do so. Dr. Schnitzer did not think it unusual that Claimant had some aches and pains upon her initial return to work. (CX. 30, p. 69). When told that Claimant only worked for three hours on February 24, 2003, and four and a half hours on February 26, 2003, Dr. Schnitzer testified that he would have expected Claimant to be able to do more, but he could not specifically comment on the effort that Claimant gave at work. (CX. 30, pp. 72-74). Dr. Schnitzer testified that he did not find Claimant to be very motivated to return to work. (CX. 30, p. 75).

Dr. Schnitzer testified that in his opinion, the job described by Tommy Sanders in an April 11, 2003 vocational report conformed to Claimant's restrictions and would have

been suitable for her. (CX. 30, pp. 71-72). When asked to review a February 27, 2003 vocational rehabilitation evaluation and labor market survey, Dr. Schnitzer testified that all the jobs listed appeared to fall within Claimant's restrictions, although he noted that he would want to know the lifting requirements for the Munro Petroleum cashier job before approving it. (CX. 30, pp. 76-78).

When asked whether Claimant's pre-existing back problems and her pre-existing psychological problems might have combined with her May 2001 workplace accident to make her materially and substantially more disabled than she otherwise would have been, Dr. Schnitzer testified that sometimes depression or anxiety disorders can affect a person's pain threshold and affect his functional capabilities, such that the person is less able to tolerate pain. (CX. 30, pp. 79-80).

Deposition of Herbert V. Allen III, M.D.

Dr. Allen is an orthopedic surgeon who first saw Claimant on March 12, 2003, on a referral from Dr. Ennis. (CX. 31, pp. 7, 9-10). He was unaware that Dr. Schnitzer recommended that Claimant see him for a second opinion. (CX. 31, pp. 10-11). Although Dr. Allen's office requested authorization for Claimant's visit, Employer's insurance company denied the request. (CX. 31, pp. 42-43). During her first appointment with Dr. Allen, Claimant complained of chronic neck pain and sharp low back pain radiating into her buttocks. She reported that her medications did not help but that she could deal with the neck pain. The back pain was Claimant's primary complaint. (CX. 31, p. 11). Claimant was unhappy with Dr. Schnitzer's care in regards to her back pain and wanted to see if Dr. Allen could help with this problem. (CX. 31, pp. 13, 53). Claimant related the history of her May 2001 workplace accident and subsequent medical treatment to Dr. Allen. (CX. 31, p. 13). Dr. Allen testified that Claimant did not relate any pre-existing back injuries to him, nor did she mention any recent back injuries dating from February 2003. (CX. 31, p. 45). Claimant did not tell him that she had previous neck or mental problems. (CX. 31, p. 48).

Upon physical examination, Claimant had about eighty percent range of motion in her neck. Hyperextension of the neck caused pain. A Spurling's test was negative, indicating no nerve impingement. Claimant's neurological exam in the upper extremities was normal with normal reflexes and grip strength bilaterally. Claimant had tenderness in the sacroiliac joints of her back, and her range of motion was seventy-five percent of normal. She had good lateral bending and rotation but had pain on flexion and extension. Dr. Allen explained that this is pretty indicative of a sacroiliac problem. (CX. 31, p. 14). Claimant's neurological exam was normal. The Patrick's test, which is specific for sacroiliitis, was positive on both sides. (CX. 31, p. 15). Dr. Allen testified that the Patrick's test, the loss of range of motion in the back and the exquisite tenderness in the sacroiliac joint were all objective findings of Claimant's back pain. (CX. 31, pp. 55-56).

Dr. Allen testified that sacroiliitis is often confused with lumbar disc disease and is common in laborers and workers. Twisting, turning, pulling cables and falling on the buttocks, right side or left side are all types of activities that can bring on this condition. (CX. 31, p. 16). Dr. Allen affirmed that crawling in confined spaces can also bring on sacroiliitis. (CX. 31, p. 17).

When asked to look at the medical report of Dr. Paul Allen, dated the day after Claimant's workplace accident, Dr. Allen acknowledged that there was no mention of Claimant's accident. (CX. 31, pp. 48-49). When asked to look at Dr. Barnes' medical report dated three days after Claimant's workplace accident, Dr. Allen noted that Claimant's complaints were consistent with her injury, even though the records did not mention that Claimant had struck her head on a pipe. (CX. 31, pp. 49-50). Dr. Allen did not think that these records were inconsistent with the history that he received from Claimant. (CX. 31, p. 50).

Dr. Allen testified that he was not really concerned with the details of Claimant's accident but rather was concerned with how to help her with the sacroiliitis. (CX. 31, pp. 18-19). He wanted to assign an impairment rating and release Claimant to light duty work as per Dr. Schnitzer's restrictions. (CX. 30, p. 19). He agreed with Dr. Schnitzer's impressions of cervical disc disease at C5-6, cervical spondylosis, mild lumbar spondylosis and neck and back arthritis. (CX. 30, p. 22). Based on Claimant's medical history and medical records and his own examination, Dr. Allen concluded that Claimant had reached MMI as to her neck with an eight percent impairment. He felt that she had active sacroiliitis on the right side, so he injected both side joints and gave Claimant some lumbar extension exercises. He intended to get Claimant's back pain under control and then have a functional capacity assessment to evaluate how much work she could do (CX. 31, p. 24). In the meantime, Dr. Allen kept Claimant off work for four weeks. (CX. 31, p. 25). Dr. Allen affirmed that in his opinion, Claimant's sacroiliitis was related to her workplace accident. (CX. 31, pp. 24-25).

Dr. Allen explained that the injections that he gave Claimant were composed of three different medications, including a corticosteroid, a short-acting numbing medication and a long-acting numbing medication. Upon injection, the joint immediately becomes numb. (CX. 31, p. 26). It then takes about twenty-four hours for the cortisone to dissolve. Dr. Allen described this type of injection as both a diagnostic and a therapeutic tool. (CX. 31, p. 27). Claimant's condition improved slightly with the injections. She was to follow up with Dr. Allen on March 26, 2003. (CX. 31, p. 29).

When Dr. Allen saw Claimant on March 26, her sacroiliitis was much better, although she reported neck pain and some right leg pain at night. Claimant had fifty percent range of motion of her cervical spine. Her straight leg raising test was negative, as were her stretch signs on both sides. Claimant had no tenderness in the sacroiliac joint. Dr. Allen felt that the injections had helped Claimant. (CX. 31, p. 30). He did not know why she continued to experience right leg pain at night but thought that Neurontin

would help with that condition. (CX. 31, pp. 30-31). Claimant was to return to see Dr. Allen in two months and to continue treating with Dr. Schnitzer for her cervical problems. (CX. 31, p. 31). Dr. Allen made no recommendations as to Claimant's work status because the FCE that he ordered had not yet been approved. (CX. 31, pp. 31-32).

Dr. Allen last saw Claimant on April 15, 2003. She was still having low back pain but no longer had leg pain or swelling. Claimant exhibited tenderness in the sacroiliac joints and had a positive Patrick's test. A straight leg raising test was negative, and Claimant had no neurological defects. She had mild edema in her feet. (CX. 31, p. 32). Dr. Allen diagnosed Claimant with recurrent sacroiliitis and told her that Neurontin was causing some of the swelling in her feet. (CX. 31, pp. 32-33). Dr. Allen testified that the foot swelling was not a disabling condition and was simply a result of the increase in her daily dosage of this medication. (CX. 31, p. 60). He reinjected her side joints and planned to see her again in two months. Dr. Allen testified that Claimant would need to return in two months if she continued to have back problems, but if not, she probably needs an FCE to see how much work she can do.

When asked about further treatment if Claimant's back continued to hurt, Dr. Allen explained that two contributing factors to sacroiliitis are a weak back and overuse, so doctors try to stabilize the condition and then prescribe a program for lumbar extension exercise and teach the patient how to use the back better. (CX. 31, p. 33). Dr. Allen did not know whether Claimant did the exercises that he recommended but observed that most patients do not do the exercises because they do not understand the concept of increasing the muscles in their backs to counteract the effects of sacroiliitis. (CX. 31, p. 34).

When asked about whether climbing steep stairs at work could have brought on some sacroiliitis symptoms for Claimant, Dr. Allen responded that it depended upon how long she was off work before returning to work. He explained that if Claimant had been off work for more than a few months, the pain in her back was deconditioning because she no longer had enough muscles to climb the stairs. (CX. 31, p. 35). He pointed out that Claimant had never really rehabilitated since her May 2001 injury. (CX. 31, p. 36).

Dr. Allen's suggested plan of action for Claimant included having an FCE done, getting a job description from Employer and then embarking on a six-week reconditioning program. If Claimant continued to have problems after six weeks, then Dr. Allen might give her more restrictions and put her at a lighter duty level. (CX. 31, p. 37). He also suggested ordering another FCE after the six-weeks of reconditioning to determine Claimant's capabilities. (CX. 31, p. 38). According to Dr. Allen, reconditioning involves the exercise bicycle, lumbar extension exercises, physical therapy and upper body extremity work. The patient goes through a work hardening program, simulating actual work activities. (CX. 31, p. 39). The importance of a reconditioning program is to prevent a claimant from returning to work and exacerbating a previous injury. (CX. 31, p. 65). With sacroiliitis, a patient will often have

exacerbations and remissions of low back pain, and a physical therapy program must take that into account. (CX. 31, p. 66). In Dr. Allen's opinion, if the pain in Claimant's back could be controlled, she would work as hard as she could at the shipyard. He felt that Claimant had situational depression due to the fact that she has a chronic back problem which prevents her from working. (CX. 31, p. 64).

Dr. Allen acknowledged that he had no way of knowing what activities that Claimant was capable of performing in November 2002. (CX. 31, p. 58). He also did not know that Claimant had undergone two previous FCEs. Claimant did not tell Dr. Allen that she had exaggerated her symptoms on at lease one of the FCEs. Dr. Allen did not have all of Claimant's medical records pertaining to her May 2001 injury, nor was he interested in them. (CX. 31, p. 59). Dr. Allen was not concerned with the results of Claimant's previous FCEs. (CX. 31, p. 62).

Dr. Allen never performed any Waddell's tests to determine whether Claimant's subjective complaints were proportional to the objective findings, because he typically relies on an FCE for those determinations. (CX. 31, pp. 60-61). He testified that sometimes patients try to do more than they are able to do on an FCE. According to Dr. Allen, grip strength and heart rate are good objective indicators of whether a patient is giving maximum effort. In his experience, most patients give a good effort on FCEs, but he acknowledged that sometimes workers' compensation patients do exaggerate their pain on an FCE. (CX. 31, p. 61).

Dr. Allen affirmed that Claimant did not show up for her last appointment with him, scheduled for May 21, 2003, but he did not know whether she was dissatisfied with his care or was treating with another doctor. (CX. 31, p. 53). Dr. Allen did not know whether Claimant is still experiencing back pain. (CX. 31, p. 65). Dr. Allen testified that he has "no idea" whether Claimant is able to work or not. (CX. 31, p. 66).

Recorded Statement of Betty Jane Stennis

Ms. Stennis is a laborer who works for Employer. She witnessed Claimant's accident on May 6, 2001. (CX. 32, p. 1). Ms. Stennis stated that she and Claimant were in the engine room cleaning in the bilges with the painters when Claimant slipped and hurt her back. (CX. 32, pp. 1-2). Claimant told Ms. Stennis that she had bumped her back on something. Claimant did not mention hurting any other part of her body besides her back. Ms. Stennis was unaware whether Claimant had ever had back problems on the job before that day, and she never saw Claimant after the day of the accident. (CX. 32, p. 2).

Recorded Statement of David Devon Kelley

Mr. Kelley is a labor foreman for Employer. Claimant worked under Mr. Kelley for fifteen or twenty years. (CX. 32, p. 3). According to Mr. Kelley, Claimant's job

performance was fair, but her attendance was poor and she had only worked about six months out of the year for the last ten or twenty years. (CX. 32, pp. 3-4). Mr. Kelley stated that Claimant was working in the engine room with the paint department on the day of her workplace accident. (CX. 32, p. 4). The day after her injury occurred, Claimant called Mr. Kelley and told him that she had hurt her back and that it was stiff the next morning when she woke up. (CX. 32, pp. 3-4). Claimant did not come in to work that day. Mr. Kelley was unaware whether Claimant had ever had any other back problems before the accident in question, and he had not spoken to her since she first informed him of the accident. (CX. 32, p. 4).

Medical Records of Paul Allen, M.D.

Dr. Allen saw Claimant on May 7, 2001, one day after her workplace accident. She complained of dysuria, low back pain and vaginal discharge and itching. In addition, Claimant complained of pains and paresthesias in the right lower extremity. She told Dr. Allen that she had an appointment to see a Dr. Lawrence for this problem in two days.[2] Dr. Allen diagnosed Claimant with cystitis and mixed vaginitis and prescribed some medications for these conditions. (CX. 10, p. 1).

Medical Records of Charlton Barnes, M.D.

Claimant first saw Dr. Barnes, an orthopedic surgeon, for the injury in question on May 9, 2001. He had previously treated Claimant for two surgeries on her right foot. Claimant presented with complaints of pain in her low back, right shoulder and right thigh. She reported that she had been off work for a while and had recently returned to shipyard employment. According to Dr. Barnes' records, Claimant had been crawling on her knees at work and had begun having problems walking two to three days earlier because her knee was hurting her. At the time of her appointment, Claimant's knee was not really hurting, but her calf and right thigh were bothering her. Dr. Barnes speculated that Claimant was having muscular problems. He planned to do a bone scan and see Claimant again in one week. He prescribed her some anti-inflammatory medication. (CX. 11, p. 5). Claimant's bone scan, taken on May 14, 2001, was unremarkable. (CX. 11, p. 6).

When Dr. Barnes next saw Claimant on May 16, 2001, she reported right shoulder, low back and leg pain. Dr. Barnes noted that Claimant's bone scan was positive for involvement at L4 and L5 in her back. He planned to do an MRI of Claimant's cervical and lumbar spine and see her again in one week. Dr. Barnes prescribed some pain medication. (CX. 11, p. 7). He also took Claimant off work retroactive to May 6, 2001, until further notice. (CX. 11, p. 8). The cervical MRI, performed on May 25, 2001, showed a bulging disc with hard disc formation more prominent at the right paracentral aspect of the C5-6 disc causing moderately severe

[2] It is clear from Claimant's testimony and the medical records, however, that Claimant was actually referring to her May 9, 2001 appointment with Dr. Barnes. (Tr. 74-75; CX. 11, p. 5).

spinal stenosis. The lumbar MRI, taken the same day, showed no evidence of lumbar disc disease but did show hypertrophic facet joint changes, resulting in mild spinal stenosis at the L4-5 level. (CX. 11, p. 9).

On May 29, 2001, Claimant returned to see Dr. Barnes. Her complaints remained the same. Dr. Barnes reported that Claimant's MRIs showed severe stenosis of her neck and mild stenosis at the L4 and L5 area. He planned to order a myelogram and see Claimant again in one week. (CX. 11, p. 11). The cervical myelogram, taken on May 31, 2001, showed moderate blunting at the left nerve root sleeve of the C5-6 space, probably reflecting a disc herniation. The lumbar myelogram, taken the same day, was normal. A CT scan of the cervical spine appeared normal, with no abnormalities at the C5-6 level. (CX. 11, p. 12). The CT scan of the lumbar spine was normal, with the facets and ligaments showing no significant hypertrophy. (CX. 11, p. 13).

On June 6, 2001, Claimant's complaints remained the same. She had difficulty raising her right shoulder. Dr. Barnes recounted the findings of each study and noted that the CT scans were normal but the myelogram showed a herniation at C5, C6. Dr. Barnes observed that although Claimant's myelogram was positive on the left, it could be a mistake and should be read as the right. He planned to see Claimant again in one week. (CX. 11, p. 14). When Dr. Barnes saw Claimant on June 12, he noted that her injury had occurred when she was pulling herself out of a hole in a ship. He planned to send her to physical therapy until her condition improved and was to see Claimant again in one week. (CX. 11, p. 15).

Claimant's initial physical therapy evaluation took place on June 13, 2001. She described the history of her accident and complained of constant throbbing and aching pain in her cervical and cervicothoracic region, radiating into her entire back. Claimant also reported constant aching and throbbing pain in her lumbar and lumbosacral region as well as periodic numbness in her right arm and right lower extremity. (CX. 11, p. 17). John Egbert, the physical therapist, physically examined Claimant, noting that it was difficult to localize her symptoms. Mr. Egbert identified Claimant's problems as follows: subjective complaints of pain in multiple areas, limited and painful cervical and lumbar motion, tenderness to palpation and limited activities of daily living. The short term therapy goals were to decrease Claimant's subjective complaints of pain by thirty percent, increase her pain-free range of motion and reduce the tenderness to palpation. The long term goals were to decrease Claimant's subjective complaints of pain by seventy percent, increase ADLs and achieve pain-free cervical and lumbar range of motion. The physical therapy plan included elements such as electrical stimulation, moist heat, ultrasound phonophoresis, therapeutic exercise, possible cervical and lumbar traction and back and neck school. Claimant was to attend physical therapy three times a week for four weeks. (CX. 11, p. 18).

On June 19, 2001, Claimant returned to see Dr. Barnes. She reported that the heat treatments to her back offered four to five hours of relief, but then the pain returned. Her

complaints remained the same. Dr. Barnes felt that Claimant needed to continue her physical therapy. Claimant was to return in one week. (CX. 11, p. 20). Claimant returned on June 27 and told Dr. Barnes that she intended to seek a second opinion. Dr. Barnes felt that this was a good idea. Claimant was to continue with physical therapy and return in two weeks. (CX. 11, p. 21). When Dr. Barnes saw Claimant on July 18, he noted that she had been seen by Dr. Guy Rutledge, who had written a letter detailing Claimant's problems and treatment options as well as distinguishing between her work-related problems and non-work-related problems. Dr. Barnes intended to give Claimant a copy of the letter. Claimant continued to complain of pain, and Dr. Barnes noted that Claimant had the option of undergoing epidural treatment. In his opinion, Claimant should continue with her physical therapy and only undergo an epidural as a last resort. Claimant was to return in two weeks. (CX. 11, p. 22).

On August 13, 2001, Claimant complained that her whole right side was hurting. She was having problems with her right shoulder and the right lateral side of her right thigh, as well as both sides of her low back. Dr. Barnes decided to send Claimant to a neurologist and order another bone scan because of her continued problems. (CX. 11, p. 23). On August 29, Claimant had no new problems. Dr. Barnes noted that Claimant had an appointment with Dr. McCloskey that week. She was to continue physical therapy with traction. (CX. 11, p. 24). When Dr. Barnes saw Claimant on September 17, she had been seen by Dr. McCloskey and Dr. Millette. Claimant's workup by Dr. Millette was normal. Dr. Barnes planned for Claimant to continue with the physical therapy and return in three weeks. (CX. 11, p. 25). On October 8, Claimant continued to have multiple aches and pains. Dr. Barnes noted that Claimant was going to see Dr. Laseter. He planned to order an FCE. (CX. 11, p. 26).

Dr. Barnes received a progress note from Mr. Egbert on October 8, 2001. Mr. Egbert reported that he had treated Claimant with moist heat, interferential electrical stimulation and ultrasound phonophoresis to her cervical, cervical thoracic, lumbar and lumbosacral regions. He had also performed soft tissue mobilization to Claimant's cervical region. Claimant had reported good temporary relief of her symptoms for up to five hours following treatment. Claimant's cervical symptoms had improved overall, but she continued to complain of periodic aching in her upper trapezius region bilaterally as well as in her lower cervical region and right upper extremity. Claimant complained of constant aching in her lumbar and lumbosacral region, radiating into her lower extremities bilaterally. Her lower extremity symptoms were worse on the right than on the left. Claimant reported that she had done a lot of housework recently, causing her pain to increase. She reported tenderness to palpation in several areas. A Waddell's test revealed positive three out of five. Mr. Egbert again noted that it had been difficult to localize Claimant's symptoms. (CX. 11, p. 27).

On October 24, 2001, Claimant's complaints to Dr. Barnes were essentially the same. She reported seeing Dr. Schnitzer and taking Celebrex. Dr. Barnes noted that he had not prescribed this medication to Claimant due to pending Celebrex-related lawsuits.

He diagnosed Claimant with tenosynovitis and returned her to work on light duty with minimal physical requirements. Claimant was to return in three weeks. Dr. Barnes told Claimant that since she continued to have problems, she could choose another doctor for a second opinion or Dr. Barnes would refer her to someone else. (CX. 11, p. 28A). On October 25, Claimant was returned to work on light duty with a ten pound weight lifting restriction. (CX. 11, p. 28B). On December 3, Claimant returned with the same complaints. Dr. Barnes noted that Claimant's bone scan from August 24, 2001, was normal. He observed that Dr. Schnitzer appeared to be helping Claimant. Dr. Barnes was pleased that Claimant continued to work. (CX. 11, p. 29). He kept her on light duty work status and planned to see her again in three weeks. (CX. 11, pp. 29, 30). There were no changes reported on December 26. Dr. Barnes noted that Claimant did not appear to have any localizing signs. Although Claimant had been attending physical therapy, Dr. Barnes observed that she did not seem to be doing very physical work. He planned to set her up for sit-ups and strengthening and see her again in a few weeks. (CX. 11, p. 31). Claimant was to continue light duty work. (CX. 11, p. 32).

On January 9, 2002, Claimant had no new complaints. She had undergone an FCE which showed a light to medium work capacity. Claimant reported that pushing in the area over her right clavicle was painful and made her nauseous. Dr. Barnes had no explanation for this reaction. He noted that Claimant was going to see a pain management doctor on January 18. She was to return to see Dr. Barnes in three weeks. (CX. 11, p. 33). Claimant's light duty restrictions were continued. She was not to do any crawling or any lifting over twenty pounds occasionally or ten pounds frequently. (CX. 11, p. 34). On January 30, Claimant reported that she had seen the pain management doctor a week previous. Claimant had been prescribed anti-inflammatories and muscle relaxants, and Dr. Barnes observed that this treatment seemed to help her. He recommended a chemistry profile, a bone scan and cervical and lumbar MRIs because Claimant continued to have problems. (CX. 11, p. 35). Claimant was released with light to medium carrying restrictions. (CX. 11, p. 36).

On April 24, 2002, Claimant had no new complaints. Dr. Barnes noted that Claimant continued to treat with a pain management doctor. Her functional capacity was read as having a validity of sixty-three percent. Her MRI showed cervical spinal stenosis, probably secondary to a herniated disc. Claimant told Dr. Barnes that she wanted to speak with Dr. McCloskey about her cervical stenosis. She was to consult with Dr. McCloskey and return in a couple of weeks. (CX. 11, p. 37). Dr. Barnes retained Claimant's light duty carrying restrictions. (CX. 11, p. 38).

Medical Records of Guy L. Rutledge III, M.D.

Claimant saw Dr. Rutledge for a second opinion evaluation on July 9, 2001. Claimant reported the history of her injury and subsequent medical treatment, explaining that she had been cleaning beneath some pipes in an engine room for one to two days when she began to experience some neck and back stiffness that gradually increased over

the next few days. She exhibited pain when turning her head to the right and reported numbness in the right leg globally as well as numbness in both feet. Upon physical examination, Claimant had a full range of motion of the cervical spine. Neck extension and rotation caused increased discomfort. Although Claimant had tenderness of the right paracervical muscles and at the right AC joint, she had full range of motion in the shoulder with no weakness. The motor and reflex exam was normal. With regard to her lumbar spine, Claimant showed mild pain on extremes of motion. Her hip range was free, and her toe/heel walk was normal.

Dr. Rutledge reviewed Claimant's MRIs and noted that although there was a defect at C5-6 and a mild facet change at L4-5, there were no real encroachments in either area. Dr. Rutledge concluded that Claimant's current difficulties were causally related to her injury. He thought that Claimant might benefit from cervical and lumbar epidurals. Claimant requested an epidural, and Dr. Rutledge planned to proceed with this treatment, provided that Employer authorized it. In Dr. Rutledge's opinion, Claimant was able to work in a light duty capacity with no work at or above shoulder level and no work on her hands and knees. He also mentioned a weight lifting restriction but did not specify the number of pounds for this restriction.

According to Dr. Rutledge, it was likely that, given Claimant's degree of disc degeneration, her symptoms would recur in the shipyard work environment. Assuming that Claimant could not be fully rehabilitated, Dr. Rutledge rated her permanent anatomic impairment at four percent whole man cervical and five percent whole man lumbar, one-half of which was related to her workplace injury and one-half of which was related to her pre-existing degenerative disc disease. Dr. Rutledge did not think that Claimant was a surgical candidate at that point but did feel that she might be fully rehabilitated with time and formal physical therapy. (CX. 16, p. 1).

Medical Records of John J. McCloskey, M.D.

Dr. McCloskey, a neurosurgeon, first treated Claimant in 1995 for some back and right leg pain. (CX. 12, p. 9). On October 28, 1995, Claimant saw Dr. McCloskey on a referral from Dr. Ennis. She reported injuring her back at work while carrying a water bucket. She complained of back and right leg pain, and an MRI scan of her low back indicated a small central disc bulge at L5 and the appearance of a mild lateral recessed stenosis at L4. Dr. McCloskey diagnosed Claimant with acute low back syndrome with right leg pain and noted possible hip problems and neck and shoulder complaints. He did not think that surgery was warranted and planned to treat Claimant conservatively with anti-inflammatories and physical therapy. (CX. 12, p. 35). Claimant did undergo physical therapy for this injury, which apparently resolved. (CX. 12, pp. 9, 29).

Dr. McCloskey first saw Claimant for the injury in question on September 1, 2001. Claimant went to Dr. McCloskey for a second opinion as to her low back pain. Claimant presented with complaints of neck pain, headache, bilateral shoulder pain, pain,

numbness and tingling in arms and hands, particularly on the right side, low back pain, constant throbbing pain in right leg and calf and somewhat on the left. She described the history of her workplace accident and subsequent medical treatment. Claimant told Dr. McCloskey that she was totally disabled and could not do anything. (CX. 12, p. 9).

Upon physical examination, Claimant walked around slowly. (CX. 12, pp. 9-10). She was able to extend her neck, which caused pain to radiate to her right arm. The Phalen test was positive bilaterally, more so on the right. Claimant's low back was stiff, and straight leg raising caused back pain. Claimant's radial pulses were intact. Her reflexes were normal and she had no focal weakness in her legs. Dr. McCloskey's impressions included post-traumatic cervical syndrome, suspected bilateral carpal tunnel syndrome, post-traumatic low back syndrome and history of migraines. Dr. McCloskey planned to obtain Claimant's actual MRI and myelogram films. He recommended electrical studies of both arms. He did not think that Claimant suffered from a radicular syndrome in her neck or back, nor did he think that her condition required surgery. He thought Claimant's best course of treatment was physiatry. He planned to make further recommendations after studying the films and obtaining the results of the electrical studies. (CX. 12, p. 10).

On September 10, 2001, Dr. Millette, a neurologist, performed a nerve conduction velocity study on both of Claimant's upper extremities. No abnormalities were revealed. An electromyography study also revealed no abnormalities. (CX. 12, p. 17). In a letter dated September 12, Dr. McCloskey informed Claimant that her MRI scan revealed a very minor-looking abnormality in her low back, as well as some abnormality in her neck at C5-6. Dr. McCloskey told Claimant that he did not think surgery was recommended in this case. He suggested that she be referred to a rehabilitation specialist and planned to follow up regarding that. (CX. 12, p. 20). In a letter dated September 25, Dr. McCloskey told Claimant that the results of her electrical studies were normal. He noted his awareness that Claimant had an appointment scheduled with Dr. Schnitzer for October 12. (CX. 12, p. 24).

Dr. McCloskey next saw Claimant on July 4, 2002. Claimant reported generally the same complaints. Dr. McCloskey noted that Claimant had been treated by Dr. Schnitzer and physical therapist Ruth Bosarge. Claimant's condition had improved somewhat, and she eventually had returned to work. Despite working in a limited duty capacity, Claimant continued to have problems at work. She seemed anxious and depressed. Neck extension caused pain, numbness and tingling radiating down the right arm toward the hand. A straight leg raising test was positive on the right with production of posterolateral right leg pain. A straight leg raising test on the left caused low back and left buttock pain. Claimant's grip was weak. The Phalen test was not positive. Dr. McCloskey diagnosed Claimant with possibly symptomatic cervical disc disease at C5-6 and apparently symptomatic lumbar canal stenosis at L4-5. (CX. 12, p. 56). He recommended a repeat myelogram because he had never seen Claimant's first myelogram. In addition to that, Dr. McCloskey noted that since the last time he saw her,

Claimant had developed a clear-cut radicular syndrome in her right arm and to a certain extent in her right leg. He requested a cervical and lumbar myelogram and prescribed Lortab for use during the procedure. (CX. 12, p. 57).

Claimant's post-myelogram CT of the lumbar spine, taken on July 16, 2002, showed moderate facet hypertrophic changes with facet erosions at L4-5 but did not show any significant disc displacement or spinal or foraminal stenosis. A post-myelogram of the cervical spine, taken the same day, showed a minimal central disc bulge at C4-5, modest spinal stenosis at C5-6 secondary to bulging disc and associated osteophytes and suspected uncovertebral erosions, which had not significantly changed since the May 2001 study. (CX. 12, p. 64). In a letter dated July 21, Dr. McCloskey told Claimant that her low back abnormalities were minor and were likely responsible for her back and right leg pain. Dr. McCloskey felt that the abnormality in Claimant's neck at C5-6 was more significant and possibly indicated nerve compression going into her right arm. He wanted to see Claimant again to decide on the best course of action with regard to this problem. (CX. 12, p. 69).

On August 1, 2002, Claimant returned to see Dr. McCloskey. Dr. McCloskey noted that Claimant had not been to physical therapy recently and that she had never undergone an epidural. Neck extension caused some numbness and tingling to radiate down the right arm, but not to the same degree as on Claimant's last appointment. Dr. McCloskey's impressions were suspected symptomatic disc herniation at C5-6 with radiculopathy in the right arm and suspected lumbar canal stenosis at L4-5 with radiculopathy in the right leg. Although Dr. McCloskey believed that there were identifiable problems in Claimant's back, he noted that these problems were not severe enough and did not absolutely correlate to her symptoms. He concluded that he would be reluctant to recommend surgery. (CX. 12, p. 70). Dr. McCloskey wanted Ms. Bosarge to re-evaluate Claimant and relate her impressions to him. (CX. 12, pp. 70-71). He suggested that Claimant be considered for a cervical and possibly a lumbar epidural cortisone injection. Claimant would continue to treat with Dr. Schnitzer. (CX. 12, p. 71).

In a letter to Employer's attorney dated August 1, 2002, Dr. McCloskey opined that Claimant's pre-existing degenerative lumbar disc disease and back problems combined with her current injury to render her materially and substantially more disabled than she would have been from her May 2001 injury alone. (CX. 12, p. 75). Dr. McCloskey also pulled Claimant from work, retroactive to June 12, 2002, until further notice. (EX. 20, p. 32).

Ms. Bosarge conducted a physical therapy evaluation of Claimant on August 13, 2002. At that time, Claimant complained of pain in both sides of her neck, radiating into her right upper extremity down through her hand. Claimant also reported daily headaches and numbness and tingling in both arms. Claimant described pain and paresthesias below both knees, particularly on the right side. After examining Claimant, Ms. Bosarge concluded that Claimant's neck and upper extremity symptoms appeared to

be originating from the C4 through C6 levels. According to Ms. Bosarge, Claimant was a good candidate for a cervical epidural, followed by a brief course of physical therapy treatment. (CX. 12, p. 80). Ms. Bosarge thought that Claimant's lower extremity symptoms were originating from the right L5-S1 facet joint and the superior pole of the right sacroiliac joint. (CX. 12, pp. 80-81). She suggested that injections into these areas would be beneficial.

Ms. Bosarge speculated that Claimant's recurring problems might be due to the nature of her duties at the shipyard. Claimant was doing a lot of upper body work. Ms. Bosarge noted that close attention should be paid to Claimant's job duties if and when she returned to work. Although Claimant had previously undergone an FCE in 2001, Ms. Bosarge thought that Claimant would probably test at a lower level now. She suggested a repeat FCE after the injections and a brief course of physical therapy. (CX. 12, p. 81).

In a letter dated September 2, 2002, Dr. McCloskey informed Employer's insurance adjuster that he had mistakenly made a work determination regarding Claimant. He noted that Dr. Schnitzer would be the appropriate physician to make such determinations and apologized for the confusion. (CX. 12, p. 85).

On September 10, 2002, Claimant underwent a cervical epidural steroid injection and was discharged in good condition. (CX. 14, p. 2). On November 13, 2002, she underwent another injection and was to follow up with Dr. Schnitzer. (CX. 15, pp. 2-3).

Medical Records of Calvin Ennis, M.D.

On June 27, 2002, Dr. Ennis, Claimant's family physician, took Claimant off work retroactive to May 6, 2002, until further notice. (CX. 21, pp. 43-44). Dr. Ennis noted that Claimant had been unable to work since May 6 due to cervical myofascial syndrome and that she had been referred to Dr. McCloskey. (CX. 21, p. 44).

On March 10, 2003, Dr. Ennis signed a return to work slip indicating that Claimant had been under his care since February 27, 2003, and that she was to return to work on March 12, 2003. (CX. 21, p. 46).

On April 17, 2003, Dr. Ennis took Claimant off work retroactive to April 16, 2003, until further notice. (CX. 28, p. 13).

On May 22, 2003, Dr. Ennis signed a return to work slip indicating that Claimant had been under his care since February 27, 2003, and that she was able to return to work as of May 26, 2003. (CX. 28, p. 15).

Functional Capacity Evaluations

October 18, 2001 FCE

According to this FCE, Claimant did not give a maximum effort, and there was evidence of symptom magnification. Claimant performed functional tasks at the light to medium duty level. She was able to lift thirty-five pounds occasionally, fifteen pounds frequently and seven pounds constantly. The physical therapist noted that pain was the major limiting factor for Claimant and that she might benefit from a general fitness program directed to increase overall muscle strength. The physical therapist also commented that because of the possibility that Claimant was engaging in symptom magnification, a maximal work capacity could not be evaluated. (CX. 17, p. 41).

April 15, 2002 FCE

This FCE indicated that Claimant gave a poor effort during the evaluation. She had negative Waddell's and Korbon's signs. Claimant performed at the light duty level. She was able to lift twenty pounds from the floor occasionally. She was able to lift fifteen pounds to the shoulder and sixteen pounds overhead. She was able to push thirty pounds and pull twenty-five pounds of weight. Claimant performed all non-material handling tasks with varying degrees of frequency. Claimant demonstrated simple grasping, fine work and low speed assembly. She met the criteria for balance and arm/foot controls. (CX. 20, p. 44).

November 18, 2002 FCE

This FCE indicated that Claimant gave maximum effort. The FCE was negative for symptom magnification. Claimant was placed in the light to medium work duty category. Once again, her weight restrictions were thirty-five pounds occasionally and fifteen pounds frequently. Claimant demonstrated full cervical range of motion in all gross planes. She had some difficulty in performing repetitive squatting tasks, requiring the use of external support. At Employer's request, the physical therapist refrained from making any return to work recommendations. The physical therapist did suggest, however, that limitations should be placed upon repetitive reaching above shoulder level with the right upper extremity. (CX. 19, p. 2).

Vocational Rehabilitation Reports of Tom Stewart, M.S., C.R.C.

On February 18, 2003, Mr. Stewart, a vocational rehabilitation counselor, met with Claimant to conduct a vocational rehabilitation evaluation. (EX. 23, p. 4). In a report to Employer's insurance adjuster, Mr. Stewart recounted the history of Claimant's workplace injury and subsequent medical treatment as well as her personal and social background and educational and vocational history. (EX. 23, pp. 4-7). He noted that Dr. Schnitzer had placed Claimant at MMI in November 2002 with the following restrictions:

light to medium duty, occasional lifting limit of thirty-five pounds, frequent lifting limit of fifteen pounds, no continuous squatting or overhead work or crawling and no work at unprotected heights.

At the time of their interview, Claimant reported moderate to severe neck, low back and leg pain, occurring on a constant basis. She also reported episodic headaches and told Mr. Stewart that almost any physical activity exacerbated her pain and discomfort. (EX. 23, p. 5). Claimant told Mr. Stewart that although she did not feel that she could work eight hours a day at any job, she would be willing to try any job. (EX. 23, p. 4).

Based on Claimant's prior work history, Mr. Stewart could determine no specific lighter transferable skills that would be of value to any prospective employer with higher-paying light duty jobs. According to Mr. Stewart, Claimant was able to work at a fairly wide range of unskilled, sedentary to light jobs. He suggested certain job possibilities for which Claimant would be qualified, such as a front desk clerk or night auditor at a motel, a convenience store clerk, a fuel booth cashier, a security/gate guard and a Players Club representative at a local casino. These jobs offered entry-level wages ranging from $5.50 to $7.50 per hour.

After conducting a labor market survey, Mr. Stewart identified five job openings in the Pascagoula/Moss Point/Biloxi area. (EX. 23, p. 7). Swetman Security Services had two gate guard openings at the front gate of the Chevron Plant in Pascagoula. The job pay started at $6.68 per hour for a forty hour a week job. No previous experience was necessary, and training was provided. The job applicant was required to have basic literacy skills and a clean felony record. The gate guard would remain at a designated gate entrance, checking vehicles in and out as needed and maintaining a simple log book. Walking was limited to fifteen to twenty feet from the guard shack to check vehicles in and out. The guard could sit and stand as needed. The job was classified at the sedentary to light duty level.

Munro Petroleum was hiring cashiers in the Pascagoula and Ocean Springs areas at an entry-level wage of $6.00 per hour for twenty to thirty-six hours a week. The pay rate would increase after thirty days of employment. The applicant had to be willing to work any available shift. No previous experience was necessary, and training was provided. The applicant was required to have basic literacy skills and money-handling ability. The primary duties included cashiering and greeting customers. The cashier would have no stocking duties and could sit and stand as needed.

Pinkerton Security Services in Pascagoula had openings for unarmed security and gate guards. The entry-level wages ranged from $5.90 to $6.90 per hour, with a work week ranging from twenty to forty hours, depending on staffing requirements. Applicants needed a high school diploma or a GED and a clean felony record and had to complete simple incident and shift reports on a daily basis. The primary duties of the

security guard job included making walking rounds twenty to thirty minutes per hour, or once every two hours, checking for open entrances, unauthorized personnel and fire hazards. The gate guard position did not involve walking rounds. This job was classified at the sedentary to light duty level.

Imperial Palace Casino in Biloxi had two job openings for PBX operators. Wages started at $7.50 per hour for sixteen to thirty-eight hours a week. Full benefits were provided. The applicant needed a high school diploma or GED as well as some simple keyboard entry skills and the ability to work any available shift. No experience was necessary, and training was provided. The primary duties of this job included handling all incoming calls and routing to the correct department or person. A pleasant attitude with the callers and a clear phone voice were required. This job was classified as sedentary. (EX. 23, p. 8).

Grand Casino and Hotel in Biloxi had two openings for Players Club representatives to work any shift needed. The entry-level wages ranged from $7.50 to $8.50 for a thirty-eight hour work week. Full benefits were available. Although experience was preferred, training was available for applicants with pleasant personalities, high school education and basic computer input experience. The primary duties included enrolling guests in the Players Club and explaining the benefits of membership. The representative could sit or stand when performing the enrollments and computer input duties. Mr. Stewart believed that this job was a sedentary position. (EX. 23, p. 9).

On February 24, 2003, Mr. Stewart wrote Claimant a letter detailing the results of the labor market survey. (EX. 23, p. 2). He recommended that if Claimant was interested, she should follow up on those job possibilities as soon as possible. (EX. 23, p. 3).

In a summary sheet dated February 27, 2003, Mr. Stewart identified three employment opportunities which were available as November 25, 2002, the date that Claimant reached MMI. (EX. 23, pp. 10-11). Pinkerton had numerous security and gate guard positions available as of that day, at a wage of $5.90 to $6.90+ for twenty to thirty hours a week. Munro Petroleum and Coastal Energy both had more than one cashier position available. At Munro, the entry-level wage was $6.00 for a twenty to thirty-six hour work week. At Coastal Energy, wages began at $6.50 per hour for twenty-four to forty hours a week. (EX. 23, p. 11).

Vocational Rehabilitation Reports of Joe Walker, C.R.C.

In a letter dated February 26, 2003, Mr. Walker, a vocational consultant, informed Claimant that he had been authorized to monitor her return to work activity as of February 24. (EX. 24, p. 4).

Mr. Walker then wrote a vocational rehabilitation report which followed Claimant from February 24 through March 13, 2003. (EX. 24, p. 6). On February 24, Mr. Walker spoke with Employer's employee relations representative and Employer's insurance adjuster, who reported that Claimant had returned to work as requested. Mr. Walker reviewed the history of Claimant's injury and subsequent treatment as well as her return to work and leave from work periods. (EX. 24, pp. 7-8).

On February 27, 2003, Mr. Walker spoke with Claimant's labor foreman, who acknowledged his awareness of Claimant's work restrictions, which he had discussed with Claimant's supervisor. Claimant had been assigned to a ship hull which was in the final phases of completeness, such that the clean-up work would be in the light range of activity and would not require heavy exertion. Access to the hull was by a standard platform with one level set of stairs, numbering about fifteen steps, with a handrail. After climbing the stairs, an employee would cross the gangway to the quarterdeck area and then climb an angular stairway with handrails. Mr. Walker learned that Claimant had reported to her foreman at about noon on February 24, at which time her supervisor assigned Claimant to work in the main deck area of the hull. Claimant did not come to work the next day and turned in an excuse to her supervisor, indicating that she had taken off work to be with her daughter, who was undergoing surgery that day. (EX. 24, p. 9).

When Claimant returned to work on February 26, she called her foreman to ask for transportation from the parking lot to the work area. Claimant reported to her work area, where her supervisor assigned her to work in the main deck area again. Claimant performed light duty tasks for about four and a half hours, clocking out early at 11:30 a.m. After that point, no one at the shipyard heard from Claimant again. On March 11, 2003, Claimant was automatically terminated. (EX. 24, p. 10).

Vocational Rehabilitation Report of Tommy Sanders, C.R.C.

On April 11, 2003, at the behest of Employer's insurance adjuster, Mr. Sanders, a rehabilitation counselor, evaluated the job duties performed by Claimant upon her February 24, 2003 return to work at the shipyard. Mr. Sanders noted that Claimant's restrictions included limited climbing, no work at unprotected heights, limited/no constant crawling, limited lifting of up to fifteen pounds frequently, limited/no constant overhead work and no constant squatting. Claimant's foreman told Mr. Sanders that all tasks assigned to Claimant were well within these restrictions. (EX. 25, p. 1). Mr. Sanders reviewed the history of Claimant's brief return to work. (EX. 25, pp. 1-2). He noted that after leaving the shipyard early on February 26, Claimant eventually returned on March 10 but had already been terminated due to the company policy that seven days of unexcused absences resulted in termination.

Claimant's foreman showed Mr. Sanders the areas where Claimant had been assigned during her return to work. Claimant's duties included wiping down walls, including beams that were located approximately thigh high and chest high. These

cleaning duties required frequent use of the upper extremities when utilizing a shop rag and a spray bottle or gallon bucket half filled with water and cleansing material. The task of cleaning the walls would require alternate bending, squatting and working from an upright position as well as perhaps slightly overhead. Mr. Sanders and the foreman then descended another twelve steps into a second deck, where Claimant had been asked to wipe down electrical boxes mounted on the bulkhead/walls, as well as wiping down the walls themselves. The boxes were staggered from approximately knee high to chest high. Cleaning them would require alternate bending, squatting and working from an upright position.

The foreman estimated that the heaviest amount that Claimant would have to lift would be approximately five pounds. Claimant could sit her water bucket on a beam or hold it in her hand. Claimant would not have to leave her assigned area except for restroom and lunch breaks. Any additional cleaning supplies were located approximately 100 yards from the ship. If Claimant had continued to work in the shipyard, she would have eventually been assigned to clean another ship, performing tasks such as sweeping passageways and compartments and picking up trash. Picking up trash would require occasional squatting and bending at the waist. Claimant would have been able to empty her trash containers as often as necessary to avoid exceeding her lifting capabilities.

After speaking with the foreman, studying Dr. Schnitzer's work restrictions and observing Claimant's assigned work area, Mr. Sanders determined that suitable work was available for Claimant in the shipyard because the job assigned to her when she left did not require frequent climbing, crawling, overhead work, squatting or working at unprotected heights. (EX. 25, p. 2). Likewise, Mr. Sanders believed that the sweeping and trash pick-up job proposed by Claimant's foreman also was in accordance with her restrictions. (EX. 25, p. 3).

IV. DISCUSSION

In arriving at a decision in this matter, it is well-settled that the fact-finder is entitled to determine the credibility of the witnesses, weigh the evidence and draw his own inferences from it and is not bound to accept the opinion or theory of any particular medical examiner. Todd Shipyards v. Donovan, 200 F.2d 741 (5th Cir. 1962); Atlantic Marine, Inc. and Hartford Accident & Indem. Co. v. Bruce, 666 F.2d 898, 900 (5th Cir. 1981); Banks v. Chicago Grain Trimmers Ass'n, Inc., 390 U.S. 459, 467, reh'g denied, 391 U.S. 928 (1968). It has been consistently held that the Act must be construed liberally in favor of the claimants. Voris v. Eikel, 346 U.S. 328, 333 (1953); J.B. Vozzolo, Inc. v. Britton, 377 F.2d 144 (D.C. Cir. 1967).

However, the United States Supreme Court has determined that the "true-doubt" rule, which resolves factual doubt in favor of the claimant when evidence is evenly balanced, violates Section 7(c) of the Administrative Procedure Act, 5 U.S.C. § 556(d),

which specifies the proponent of a rule or position has the burden of proof. Director, OWCP v. Greenwich Collieries, 512 U.S. 267 (1994), aff'g 990 F.2d 730 (3d Cir. 1993).

Credibility

An administrative law judge has the discretion to determine the credibility of witnesses. Furthermore, an administrative law judge may accept a claimant's testimony as credible, despite inconsistencies, if the record provides substantial evidence of the claimant's injury. Kubin v. Pro-Football, Inc., 29 BRBS 117, 120 (1995); see also Plaquemines Equip. & Mach. Co. v. Newman, 460 F.2d 1241, 1243 (5th Cir. 1972).

I found Claimant in this case to be a reasonably credible witness and I have weighed her testimony accordingly.

Causation

Section 20(a) of the Act, 33 U.S.C. § 920(a), provides a claimant with a presumption that his injury was causally related to his employment if he establishes that he suffered a physical injury or harm and that working conditions existed or a work accident occurred which could have caused, aggravated or accelerated the condition. Gencarelle v. General Dynamics Corp., 22 BRBS 170 (1989).

The first prong of Claimant's prima facie case requires him to establish the existence of a physical harm or injury. The Act defines an injury as the following:

> accidental injury or death arising out of and in the course of employment, and such occupational disease or infection as arises naturally out of such employment or as naturally or unavoidably results from such accidental injury, and includes an injury caused by the willful act of a third person directed against an employee because of his employment.
>
> 33 U.S.C. § 902 (2).

An accidental injury occurs when something unexpectedly goes wrong within the human frame. See Wheatley v. Adler, 407 F.2d 307 (D.C. Cir. 1968). Additionally, an injury need not involve an unusual strain or stress, and it makes no difference that the injury might have occurred wherever the employee might have been. See Wheatley; Glens Falls Indemnity Co. v. Henderson, 212 F.2d 617 (5th Cir. 1954).

The claimant's uncontradicted credible testimony may alone constitute sufficient proof of physical injury. Hampton v. Bethlehem Steel Corp., 24 BRBS 141 (1990); Golden v. Eller & Co., 8 BRBS 846 (1978), aff'd, 620 F.2d 71 (5th Cir. 1980). In relating the injury to the employment, however, the claimant must show the existence of

working conditions which could have conceivably caused the harm alleged. See Champion v. S&M Traylor Bros., 690 F.2d 285, 295 (D.C. Cir. 1982).

The second prong of Claimant's prima facie case requires him to show the occurrence of an accident or the existence of working conditions which could have caused, aggravated or accelerated the condition. The 20(a) presumption does not assist Claimant in establishing the existence of a work-related accident. Mock v. Newport News Shipbldg. & Dry Dock Co., 14 BRBS 275 (1981). Therefore, like any other element of his case to which a presumption does not apply, Claimant has the burden of establishing the existence of such an accident by a preponderance of the evidence.

The Court must weigh all the record evidence, whether it supports or contradicts the claimant's testimony, in order to determine whether the claimant has met his burden in establishing the existence of a workplace accident.

Claimant in this case testified that she was injured at work in May 2001 when she was backing out of a crawl space underneath some pipes in the engine room of a ship. As Claimant attempted to get up, she hit her neck and back on the pipes, causing her a great deal of pain. In an unsworn statement, Claimant's co-worker, Ms. Stennis, verified this version of events. Claimant testified that she was unable to come into work the next day because of her pain. In an unsworn statement, Claimant's foreman, Mr. Kelley, verified that Claimant called him that morning to notify him of the accident and to tell him that she would not be coming in that day. Claimant has established a prima facie case that she sustained an injury caused by a workplace accident on May 6, 2001.

Once the claimant has invoked the presumption, the burden shifts to the employer to rebut the claimant's prima facie case with substantial countervailing evidence. James v. Pate Stevedoring Co., 22 BRBS 271 (1989). The Fifth Circuit addressed the issue of what an employer must do in order to rebut a claimant's prima facie case in Conoco v. Director, OWCP, 194 F.3d 684 (5th Cir. 1999). In that case, the Fifth Circuit held that to rebut the presumption, an employer does not have to present specific and comprehensive evidence ruling out a causal relationship between the claimant's employment and his injury. Rather, to rebut a prima facie presumption of causation, the employer must present substantial evidence that the injury is not caused by the employment. Noble Drilling v. Drake, 795 F.2d 478 (5th Cir. 1986), cited in Conoco, 194 F.3d at 690. An unequivocal opinion, given to a reasonable degree of medical certainty, that the employee's injury is not work-related is sufficient to rebut the presumption. Charpentier v. Ortco Contractors, Inc., No. 00-0812 (BRB May 9, 2001) (citing O'Kelley v. Department of the Army/NAF, 34 BRBS 39 (2000)).

If the presumption is rebutted, it no longer controls and the record as a whole must be evaluated to determine the issue of causation. Volpe v. Northeast Marine Terminals, 671 F.2d 697 (2d Cir. 1982); Del Vecchio v. Bowers, 296 U.S. 280 (1935).

Employer argues that Claimant has failed to establish a prima facie case that her neck and back injuries are work-related. In support of its argument, Employer alleges that there are numerous inconsistencies between Claimant's testimony about her workplace accident and the various medical records related to her treatment for neck and back problems. Employer cites the fact that Dr. Paul Allen, who Claimant saw one day after the workplace accident, did not mention the accident in his medical report. When Claimant saw Dr. Barnes three days after the accident, she reported that she was having right side pain after crawling on her knees at work, but Dr. Barnes later noted that Claimant's injury had occurred when she pulled herself out of a hole in a ship. Employer notes that Claimant told a physical therapist that the injury occurred when she felt a "pop" while straightening up after cleaning some bilges, and Dr. Rutledge's records indicate that Claimant's current problems stemmed from a gradual onset of neck and back stiffness over two days of work. Employer also cites the testimony of Dr. Schnitzer, who observed that the information that he obtained from Claimant was inconsistent with the history proved by Dr. Paul Allen and Dr. Barnes and that Claimant might have a pre-existing condition in her back.

Although Employer has pointed out that not all of the medical records contain the account of Claimant's accident as she described it at the hearing, Employer has not produced any evidence to indicate that Claimant's neck and back problems are not causally related to her employment. It is undisputed that Claimant reported her injury to her co-worker immediately after it occurred. It is undisputed that Claimant called her foreman the day after the accident to tell him what had happened and to report that she was unable to come in to work because of her pain. In addition, Claimant herself was a credible witness. Regardless of whether or not Claimant described the specifics of her fall at work to each doctor that she saw, Claimant did consistently report her physical problems to each doctor, beginning with Dr. Paul Allen, who she saw immediately after the workplace injury occurred. Although Claimant did not treat with Dr. Allen for her work-related injuries, she did tell him that she was having right lower leg pain and was seeing an orthopedist in two days. Dr. Schnitzer could not say for sure whether Claimant's spinal stenosis was present before her workplace injury, but he never indicated that he believed Claimant had never had a workplace injury. While Dr. Schnitzer and Dr. McCloskey did question the consistency of Claimant's subjective complaints, neither they nor any other doctors ever questioned whether she actually had sustained a workplace accident. I find that Employer has failed to rebut the presumption that Claimant's injuries are causally related to her employment. I find that causation exists as to Claimant's neck and back injuries in this case.

Nature and Extent

Having established work-related injuries, the burden rests with the claimant to prove the nature and extent of his disability, if any, from those injuries. Trask v. Lockheed Shipbldg. Constr. Co., 17 BRBS 56, 59 (1985). A Claimant's disability is permanent in nature if he has any residual disability after reaching maximum medical

improvement (MMI). James v. Pate Stevedoring Co., 22 BRBS 271, 274 (1989); Trask, 17 BRBS at 60. Any disability before reaching MMI would thus be temporary in nature. The date of MMI is a question of fact based upon the medical evidence of record. Ballestros v. Willamette W. Corp., 20 BRBS 184 (1988); Williams v. General Dynamics Corp., 10 BRBS 915 (1979). An employee reaches MMI when his condition becomes stabilized. Cherry v. Newport News Shipbldg. & Dry Dock Co., 8 BRBS 857 (1978); Thompson v. Quinton Enter., Ltd., 14 BRBS 395 (1981).

Employer argues that Claimant reached MMI on November 25, 2002, as Dr. Schnitzer determined. Claimant argues that while she may have reached MMI with regard to her neck injury as of this date, she has not yet reached MMI with regard to the sacroiliac condition in her low back. While it is true that Claimant has only recently been diagnosed with sacroiliitis by Dr. Herbert Allen, she has consistently complained about her neck and back pain ever since her May 2001 accident. There is no indication in the medical records that her back pain has increased since November 25, 2002, nor is there any evidence that she has sustained anything other than work-related flare ups in her condition since that time. Regardless of Claimant's diagnosis by Dr. Allen, the medical records indicate that she has a chronic condition in her neck and back which will never completely be healed. I find that Claimant reached MMI with regard to her neck and back on November 25, 2002.

The question of extent of disability is an economic as well as a medical concept. Quick v. Martin, 397 F.2d 644 (D.C. Cir. 1968); Eastern S.S. Lines v. Monahan, 110 F.2d 840 (1st Cir. 1940). Disability under the Act means an incapacity, as a result of injury, to earn wages which the employee was receiving at the time of the injury at the same or any other employment. 33 U.S.C. § 902(10). In order for a claimant to receive a disability award, he must have an economic loss coupled with a physical or psychological impairment. Sproull v. Stevedoring Servs. of America, 25 BRBS 100, 110 (1991). Economic disability includes both current economic harm and the potential economic harm resulting from the potential result of a present injury on market opportunities in the future. Metropolitan Stevedore Co. v. Rambo (Rambo II), 521 U.S. 121, 122 (1997). A claimant will be found to have either no loss of wage-earning capacity, no present loss but a reasonable expectation of future loss (de minimis), a total loss or a partial loss.

A claimant who shows he is unable to return to his former employment has established a prima facie case for total disability. The burden then shifts to the employer to show the existence of suitable alternative employment. P & M Crane v. Hayes, 930 F.2d 424, 430 (5th Cir. 1991); New Orleans (Gulfwide) Stevedores v. Turner, 661 F.2d 1031, 1038 (5th Cir. 1981). Furthermore, a claimant who establishes an inability to return to his usual employment is entitled to an award of total compensation until the date on which the employer demonstrates the availability of suitable alternative employment. Rinaldi v. General Dynamics Corp., 25 BRBS 128 (1991).

Claimant initially was released to work by Dr. Barnes in October 2001. She continued to work her same hours, earning her pre-injury pay, until May 4, 2002, the day that her sister died. Claimant argues that she did not return to work after this day because of her neck and back pain. Employer argues that Claimant did not return to work because she was depressed about her sister's death. Claimant was retroactively taken off work several weeks later by Dr. Ennis, her family physician, who apparently made no note of her neck and back pain.[3] (EX. 19, p. 19). When Claimant saw Dr. McCloskey in July 2002, he took Claimant off work retroactive to June 12, the day that Claimant was originally scheduled to see him, although he later informed Employer's insurance adjuster that Dr. Schnitzer would be the appropriate physician to make work determinations. For his part, Dr. Schnitzer noted when he saw Claimant in late August 2002 that she should be kept off work until her next visit. After Dr. Schnitzer saw Claimant in October 2002, he wrote a letter to Employer's insurance adjuster stating that he intended to keep Claimant off work until she underwent some physical therapy and another FCE. As noted above, Dr. Schnitzer determined that Claimant had reached MMI in November 2002.

Both Dr. McCloskey and Dr. Schnitzer were Claimant's approved treating physicians during this period of time, and both doctors felt that Claimant should be kept off work. Claimant argues that she attempted to see both doctors soon after she stopped working in May 2002, but neither doctor could give her an appointment at that time, so she went to Dr. Ennis instead. Even though Dr. McCloskey noted later that he should not be making work determinations for Claimant, he never indicated that she should have been returned to work. Rather, he deferred to Dr. Schnitzer, who also kept Claimant off work.

Despite the lack of concrete medical evidence to indicate why Claimant did not return to work in the weeks after May 3, 2002, Dr. Schnitzer did excuse Claimant from work in April 2002 after she missed several days due to her neck and back pain. This time off, combined with her attempts to see Dr. McCloskey and Dr. Schnitzer after her last day of work in May, persuade me that she was suffering from some sort of flare-up in her condition and that her doctors were justified in keeping her off work for the next few months. On the other hand, I find that Claimant's initial inability to return to work after May 3, 2002, was likely because of her sister's death, rather than her own physical difficulties, and there is no indication that she reported a flare-up to anyone at work on the day before her sister died. Accordingly, I find that Claimant was temporarily totally disabled from June 12, 2002, the date that she was first to see Dr. McCloskey, until November 25, 2002, the date that Claimant reached MMI. In addition, I find that Claimant is owed temporary total disability compensation for April 8-12, 2002, the days on which Dr. Schnitzer retroactively excused her from work. Employer shall pay Claimant temporary total disability compensation for the time period of April 8-12, 2002,

[3] I note that Dr. Ennis' medical records, including this one, are handwritten and very difficult to read and interpret. (EX. 19).

and from June 12, 2002, through November 25, 2002, based on an average weekly wage of $654.47 and a corresponding compensation rate of $436.53.

It is undisputed in this case that at the present time, Claimant is unable to return to her regular full duty employment as a shipyard laborer. I must now examine whether Employer has established that suitable alternative employment for Claimant exists.

Suitable Alternative Employment

Once a claimant has established a prima facie case for total disability, the employer may avoid paying total disability benefits by showing that suitable alternative employment exists that the injured employee can perform. The claimant does not have the burden of showing there is no suitable alternative employment available. Rather it is the duty of the employer to prove that suitable alternative employment exists. Shell v. Teledyne Movable Offshore, 14 BRBS 585 (1981); Smith v. Terminal Stevedores, 111 BRBS 635 (1979). The employer must prove the availability of actual identifiable, not theoretical, employment opportunities within the claimant's local community. New Orleans (Gulfwide) Stevedores v. Turner, 661 F.2d 1031, 1042-43, 14 BRBS 156, 164-65 (5th Cir. 1981), rev'g 5 BRBS 418 (1977); Bumble Bee Seafoods v. Director, OWCP, 629 F.2d 1327, 1330, 12 BRBS 660, 662 (9th Cir. 1980). The specific job opportunities must be of such a nature that the injured employee could reasonably perform them given his age, education, work experience and physical restrictions. Edwards v. Director, OWCP, 999 F.2d 1374 (9th Cir. 1993), cert. denied, 511 U.S. 1031 (1994); Turner, 661 F.2d at 1041-1042. The employer need not place the claimant in suitable alternative employment. Trans-State Dredging v. Benefits Review Bd. (Tarner), 731 F.2d 199, 201, 16 BRBS 74, 75 (CRT) (4th Cir. 1984), rev'g 13 BRBS 53 (1980); Turner, 661 F.2d at 1043; 14 BRBS at 165. However, the employer may meet its burden by providing the suitable alternative employment. Hayes, 930 F.2d at 430.

If the employer has established suitable alternative employment, the employee can nevertheless prevail in his quest to establish total disability if he demonstrates that he tried diligently and was unable to secure employment. Hooe v. Todd Shipyards Corp., 21 BRBS 258 (1988). The claimant must establish a reasonable diligence in attempting to secure some type of suitable employment within the compass of opportunities shown by the employer to be reasonably attainable and available and must establish a willingness to work. Turner, 661 F.2d at 1043.

Employers may rely on the testimony of vocational experts to establish the existence of suitable jobs. Turney v. Bethlehem Steel Corp., 17 BRBS 232, 236 (1985); Southern v. Farmers Export Co., 17 BRBS 64, 66-67 (1985); Berkstresser v. Washington Metro. Area Transit Auth., 16 BRBS 231, 233 (1984); Bethard v. Sun Shipbldg. & Dry Dock Co., 12 BRBS 691 (1980); Pilkington v. Sun Shipbldg. & Dry Dock Co., 9 BRBS 473; 477-80 (1978). See also Armand v. American Marine Corp., 21 BRBS 305 (1988) (job must be realistically available). The counselors must identify specific available jobs;

market surveys are not enough. Campbell v. Lykes Bros. Steamship Co., 15 BRBS 380, 384 (1983); Kimmel v. Sun Shipbldg. & Dry Dock Co., 14 BRBS 412 (1981). See also Williams v. Halter Marine Serv., 19 BRBS 248 (1987) (must be specific, not theoretical, jobs). The trier of fact should also determine the employee's physical and psychological restrictions based on the medical opinions of record and apply them to the specific available jobs identified by the vocational expert. Villasenor v. Marine Maintenance Indust., 17 BRBS 99, motion for recon. denied, 17 BRBS 160 (1985). To calculate a claimant's wage earning capacity, the trier of fact may average the wages of suitable alternative positions identified. Avondale Indust. v. Director, OWCP, 137 F.3rd 326 (5th Cir. 1998).

A job within an employer's facility continues to meet the employer's burden of proof where it is suitable and available even if the claimant fails to report to work. Walters v. Ingalls Shipbldg., Inc., 31 BRBS 75 (CRT) (5th Cir. 1997). Once an employer establishes suitable alternative employment by providing light duty work which a claimant successfully performs but is subsequently discharged for breeching company rules and not for reasons related to his disability, the employer does not bear any new burden of providing other suitable alternative employment. Brooks v. Director, OWCP, 2 F.3d 64, 27 BRBS 100 (CRT) (4th Cir. 1993); see also Harrod v. Newport News Shipbldg. & Dry Dock Co., 12 BRBS 10, 14-16 (1980) (employer met burden by showing alternative job, even though the claimant was later fired for bringing a gun to work). Once a claimant is terminated for reasons unrelated to the work related disability, the employer no longer has a duty to show suitable alternative employment and has no duty to pay further compensation benefits. Darby v. Ingalls Shipbldg., Inc., 99 F.3d 685, 30 BRBS 93 (CRT) (5th Cir. 1996).

Mr. Stewart provided Employer with a list of three local employers with job opportunities retroactively available on November 25, 2002, the date that Claimant reached MMI. However, at that point, Claimant was still employed by the shipyard. Not only did the shipyard not have any job openings within her restrictions at the time, but Mr. Stewart also did not obtain information about these retroactively available jobs until after a light duty job became available at the shipyard, where Claimant could earn the same pay that she had earned before her workplace injury. I find that Employer has not established that suitable alternative employment was available for Claimant as of November 25, 2002.

In February 2003, Claimant returned to work for the second time when Employer offered her a light duty job cleaning ships. Claimant worked at this job for three hours on the day of her return. The next day, Claimant took off work to be with her daughter, who was undergoing surgery. The following day, Claimant worked for only four and a half hours before walking off the job. She argues that she was unable to do this job. Employer in this case argues that the job was within Claimant's restrictions and that she did not give a good effort before deciding that the work was too much for her. In support of its argument, Employer cites the records of two vocational rehabilitation consultants,

Mr. Walker and Mr. Sanders, both of whom investigated this job and its requirements before determining that the job did constitute suitable alternative employment within Claimant's restrictions. In addition, Dr. Schnitzer, Claimant's treating physician at the time, testified that this job conformed to Claimant's restrictions and was suitable for her. I find Dr. Schnitzer's opinion to be more probative than that of Dr. Allen as Dr. Schnitzer had been treating Claimant for a much longer period of time, was her treating physician and was aware of the many objective tests that had been performed. Dr. Schnitzer was also aware of the results of the physical therapy sessions and of the FCEs that were conducted.

At this time, Claimant's restrictions from Dr. Schnitzer included a lifting limit of thirty-five pounds occasionally and fifteen pounds frequently, no constant squatting, overhead work or crawling and no work at unprotected heights. According to the vocational rehabilitation reports, Claimant's job required her to do light duty clean-up work, including wiping down walls and electrical boxes. The cleaning duties required alternate bending, squatting and working from an upright position as well as slightly overhead. Claimant did not have to carry anything heavier than five pounds, and she was not required to crawl or work at unprotected heights.

Despite Claimant's complaints that she was unable to do this work, I find that this light duty job was well within her restrictions. In addition, I note that Claimant scarcely made an effort to do the job before walking off the job permanently, and there is no indication that Claimant ever reported her problems at work to Ms. Wiley, who had instructed Claimant to inform her if she had any difficulty doing the work assigned. I find that Employer established that suitable alternative employment was available for Claimant in the shipyard as of February 24, 2003. Because Employer established suitable alternative employment for Claimant at its facility, it was released of its duty to pay further compensation benefits after Claimant walked off the job, effectively abandoning her employment, two days after returning to work.

Employer shall pay Claimant permanent total disability benefits for the time period between November 26, 2002, and February 24, 2003, based on an average weekly wage of $654.47 and a corresponding compensation rate of $436.53.

Average Weekly Wage

Sections 10(a) and 10(b) are the statutory provisions relevant to a determination of an employee's average annual wages where an injured employee's work is permanent and continuous. Duncan-Harrelson Co. v. Director, OWCP, 686 F.2d 1336, 1342 (9th Cir. 1982), vacated in part on other grounds, 462 U.S. 1101 (1983). The computation of average annual earnings must be made pursuant to subsection (c) if subsections (a) or (b) cannot be reasonably and fairly applied. 33 U.S.C. § 910. Section 10(a) applies where an employee "worked in the employment . . . whether for the same or another employer, during substantially the whole of the year immediately preceding" the injury. 33 U.S.C. §

910(a); Empire United Stevedores v. Gatlin, 936 F.2d 819, 25 BRBS 26 (CRT) (5th Cir. 1991); Duncan v. Washington Metro. Area Transit Auth., 24 BRBS 133, 135-136 (1990); Mulcare v. E.C. Ernst, Inc., 18 BRBS 158 (1986). Section 10(b) applies to an injured employee who worked in permanent or continuous employment, but did not work for "substantially the whole of the year" prior to injury. Gatlin, 936 F.2d at 21, 25 BRBS at 28 (CRT); Duncan-Harrelson, 686 F.2d at 1341; Duncan, 24 BRBS at 135; Lozupone v. Lozupone & Sons, 12 BRBS 148, 153 (1979).

When there is insufficient evidence in the record to make a determination of average weekly wage (AWW) under either subsections (a) or (b), subsection (c) is used. Todd Shipyards Corp. v. Director, OWCP, 545 F.2d 1176, 5 BRBS 23, 25 (9th Cir. 1976), aff'g and remanding in part 1 BRBS 159 (1974); Sproull v. Stevedoring Servs. of America, 25 BRBS 100, 104 (1991); Lobus v. I.T.O. Corp., 24 BRBS 137 (1991); Taylor v. Smith & Kelly Co., 14 BRBS 489 (1981). Subsection (c) is also used whenever subsections (a) and (b) cannot reasonably and fairly be applied and therefore do not yield an average weekly wage that reflects the claimant's earning capacity at the time of the injury. Empire United Stevedores v. Gatlin, 936 F.2d 819, 25 BRBS 26 (CRT) (5th Cir. 1991); Walker v. Washington Metro Area Transit Auth., 793 F.2d 319 (D.C. Cir. 1986), cert. denied, 479 U.S. 1094 (1987); Browder v. Dillingham Ship Repair, 24 BRBS 216, 218 (1991).

Claimant argues that § 10(a) is the appropriate calculation method, as Claimant worked substantially the whole of the year preceding her injury as a full time, five day a week laborer. Claimant argues that the periods of time during which she took medical leave and personal leave to deal with family issues in the year preceding her workplace injury are not deducted from the computation of her AWW, because time loss due to strike, personal business, illness or other reasons is not deducted from the computation. Duncan v. Washington Metro Area Transit Auth., 23 BRBS 133 (1990) (citing O'Connor v. Jeffboat, Inc., 8 BRBS 290 (1978)). Employer argues that because Claimant voluntarily withdrew herself from the work force when she took leave to deal with family matters preceding her May 2001 injury, § 10(c) is the appropriate method of calculating AWW in this case.

I find that § 10(a) is the proper method of calculation in this case under the relevant Board case law, such that Claimant's lost time during her medical and personal leave of absence periods will not be deducted from the calculation. Claimant's wage records from the year preceding her May 6, 2001 injury indicate that she earned gross wages of $24,607.89 and worked for 188 days. Under § 10(a), the AWW of Claimant, a five-day worker, is calculated thus: ($24,607.89 ÷ 188) x 260 ÷ 52 = $654.47. Claimant's corresponding compensation rate is $436.53.

Medical Expenses/Choice of Physician

Section 7 of the LHWCA provides in pertinent part: "The employer shall furnish such medical, surgical, and other attendance or treatment, nurse and hospital service, medicine, crutches, and apparatus, for such period as the nature of the injury or the process of recovery may require." 33 U.S.C. § 907(a). In order to assess medical expenses against an employer, the expenses must be reasonable and necessary. Pernell v. Capital Hill Masonry, 11 BRBS 582 (1979).

Section 7(c)(2) of the Act provides that when the employer or carrier learns of an employee's injury, either through written notice or as otherwise provided by the Act, it must authorize medical treatment by the employee's chosen physician. Once a claimant has made his initial free choice of a physician, he may change physicians only upon obtaining prior written approval of the employer, carrier or deputy commissioner. See 33 U.S.C. § 907(c)(2); 20 C.F.R. § 702.406.

The employer is ordinarily not responsible for the payment of medical benefits if a claimant fails to obtain the required authorization. Slattery Assocs. v. Lloyd, 725 F.2d 780, 787, 16 BRBS 44, 53 (CRT) (D.C. Cir. 1984); Swain v. Bath Iron Works Corp., 14 BRBS 657, 664 (1982). Failure to obtain authorization for a change can be excused, however, where the claimant has been effectively refused further medical treatment. Lloyd, 725 F.2d at 787, 16 BRBS at 53 (CRT); Swain, 14 BRBS at 664; Washington v. Cooper Stevedoring Co., 3 BRBS 474 (1976), aff'd, 556 F.2d 268, 6 BRBS 324 (5th Cir. 1977); Buckhaults v. Shippers Stevedore Co., 2 BRBS 277 (1975).

It is undisputed that Claimant chose to treat with Dr. Barnes, an orthopedic surgeon, and that Employer authorized this treatment. In addition, it is undisputed that Employer also approved Dr. Barnes' referral of Claimant to Dr. McCloskey, a neurosurgeon, as well as Dr. McCloskey's referral of Claimant to Dr. Schnitzer, a pain management specialist. Although Claimant contends that Employer refused to approve any further treatment with Dr. Barnes after April 24, 2002, she acknowledged in her testimony that neither Dr. McCloskey nor Dr. Schnitzer ever referred her back to Dr. Barnes or refused to treat her.

Claimant argues that because Employer refused to authorize any further treatment with Dr. Barnes, her treating orthopedist, she was effectively denied treatment, such that her failure to obtain approval to treat with Dr. Herbert Allen, another orthopedic surgeon, is excused. In addition, Claimant argues that the treatment with Dr. Allen should be approved because she was referred to him by Dr. Schnitzer. Employer points out, however, that Dr. Barnes was not recommending any further treatment, so there was no treatment to be refused. Employer also notes that Dr. Schnitzer's referral was based on Claimant's request that she be sent to Dr. Allen for a second opinion. Dr. Schnitzer testified that he would not necessarily have recommended the referral but that he was willing to defer to Claimant's wishes on the matter.

By the time that Employer stopped authorizing Claimant's treatment with Dr. Barnes, Dr. Barnes was doing little more for Claimant than renewing her restrictions and reviewing her treatment with Drs. McCloskey and Schnitzer, who both continued to treat Claimant for some time after she stopped seeing Dr. Barnes. Employer was not required to authorize Claimant's treatment with Dr. Herbert Allen, because Claimant was not effectively refused further medical treatment, although her treatment with Dr. Barnes was no longer authorized. Claimant was still authorized to treat with Dr. McCloskey and Dr. Schnitzer. Thus, Claimant's failure to obtain authorization before treating with Dr. Herbert Allen is not excused. I find that Employer is not required to pay any of the medical expenses associated with Claimant's treatment with Dr. Herbert Allen.

I note as well that Dr. Ennis, Claimant's family physician, was never her treating physician for the May 2001 injury, and consequently, Employer is not responsible for payment of any medical expenses associated with Dr. Ennis' treatment of Claimant. In addition, Claimant has requested that the Court order Employer to pay over $500 in hospital expenses related to Claimant's November 7, 2002 visit to the Singing River Hospital emergency room after a physical therapy treatment. Because Claimant has offered no justification or excuse for why she did not seek treatment with either of her treating physicians for this situation, that request is denied.

Section 8(f) Relief

Section 8(f) shifts part of the liability for permanent partial and permanent total disability from the employer to the Special Fund, established by Section 44, when the disability or death is not due solely to the injury which is the subject of the claim. Section 8(f) has three essential elements. If those are met, an employer's liability is limited to 104 weeks of compensation. The record must establish that: (1) the employee had a pre-existing partial disability; (2) the partial disability was manifest to the employer and (3) it rendered the second injury more serious than it otherwise would have been. Director, OWCP v. Berkstresser, 921 F.2d 306, 309, 24 BRBS 69 (CRT) (D.C. Cir. 1990), rev'g 16 BRBS 231 (1984), 22 BRBS 280 (1989). The injury must be new, and the disability must not be due solely to this new injury. There is an additional requirement in cases of permanent partial disability. In those cases, the disability must be "materially and substantially greater than that which would have resulted from the new injury alone." Director, OWCP v. Ingalls Shipbldg., Inc. (Ladner), 125 F.3d 303, 306 (5th Cir. 1997).

Although I need not reach the question of § 8(f) relief in this case, where Employer is liable for payment of less than 104 weeks of compensation benefits, I will nonetheless analyze this issue for the sake of completeness. Employer has argued that Claimant had a history of neck, back and mental problems before her May 2001 workplace accident occurred. Indeed, the medical records indicate that Claimant treated with Dr. McCloskey for back pain after injuring herself at work in 1995. At that time, Dr. McCloskey noted a disc bulge and mild stenosis in Claimant's back, as well as neck

complaints, among other ailments. When Claimant was being treated for the May 2001 injury in question, Dr. McCloskey opined that Claimant's pre-existing degenerative lumbar disc disease and back problems combined with her more recent injury to render her materially and substantially more disabled than she otherwise would have been. In addition, Claimant has been treated for an adjustment disorder, dysthymia and depression since 1996, and Dr. Schnitzer testified that sometimes depression or anxiety disorders can affect a person's pain threshold and affect his functional capacities, rendering him less able to tolerate pain.

Not only is it clear that Claimant had pre-existing back and emotional problems, it is also clear that Claimant had been treated for these conditions, such that these conditions were, if not already actually known to Employer, certainly within the realm of its constructive knowledge during Claimant's tenure at the shipyard. Finally, Dr. McCloskey, Claimant's treating neurologist, having previously treated her for her 1995 work-related back problems, unequivocally stated that her pre-existing condition materially and substantially contributed to her disability following the May 2001 workplace accident. Dr. Schnitzer also indicated the possibility that Claimant's pre-existing mental health problems might have contributed to her inability to obtain significant relief from her chronic pain condition. I find that Employer has satisfied the requisite three elements to be entitled to § 8(f) relief as regards payment of compensation benefits related to Claimant's May 2001 workplace accident.

Conclusion

Based on the foregoing findings of fact, conclusions of law and the entire record, I hereby enter the following compensation order. All other issues not decided herein were rendered moot by the above findings.

ORDER

It is hereby ORDERED, ADJUDGED AND DECREED that:

1. Employer shall pay Claimant temporary total disability compensation for the time period from May 7, 2001, to October 28, 2001, based on an average weekly wage of $654.47 and a corresponding compensation rate of $436.53.

2. Employer shall pay Claimant temporary total disability compensation for the time period of April 8-12, 2002, based on an average weekly wage of $654.47 and a corresponding compensation rate of $436.53.

3. Employer shall pay Claimant temporary total disability compensation for the time period from June 12, 2002, through November 25, 2002, based on

an average weekly wage of $654.47 and a corresponding compensation rate of $436.53.

4. Employer shall pay Claimant permanent total disability compensation for the time period from November 26, 2002, through February 24, 2003, based on an average weekly wage of $654.47 and a corresponding compensation rate of $436.53.

5. Employer shall pay all reasonable and necessary medical expenses related to the treatment of Claimant's neck and low back injuries by Dr. McCloskey and Dr. Schnitzer.

6. Claimant's request for reimbursement of any and all medical expenses associated with her treatment with Dr. Ennis or Dr. Herbert Allen as well as for reimbursement of expenses associated with the November 7, 2002 Singing River Hospital emergency room visit is hereby **DENIED**.

7. Employer shall receive a credit for benefits and wages paid.

8. Employer shall pay Claimant interest on any accrued unpaid compensation benefits at the rate provided by 28 U.S.C. § 1961.

9. Within thirty days of receipt of this Order, counsel for Claimant should submit a fully-documented fee application, a copy of which shall be sent to opposing counsel, who shall have twenty days to respond.

10. All computations of benefits and other calculations which may be provided for in this order are subject to verification and adjustment by the District Director.

ORDERED this 20th day of October, 2003, at Metairie, Louisiana.

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LARRY W. PRICE
Administrative Law Judge

LWP:bbd